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 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 4235
 CERTIFICATE OF DEATH

64159

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN lb 37 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie d. STREET ADDRESS 1040 Fitzallen Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NICK Middle Last AJDINOVICH				4. DATE OF DEATH Month April Day 20 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 27, 1886	
9. AGE (In years last birthday) 73		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Burner		10b. KIND OF BUSINESS OR INDUSTRY Ship Yard		11. BIRTHPLACE (State or foreign country) Yugoslavia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Eli Ajdinovich		14. MOTHER'S MAIDEN NAME Marian MN: Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 213-07-0153		17. INFORMANT Clinical Records, VAH, Balto. 18, Md., Ft. Howard Div.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 203X IMMEDIATE CAUSE (a) MULTIPLE MYELOMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease. Pulmonary Emphysema. Osteoarthritis.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 14, 1960 to April 20, 1960 , that (I) (we) last saw the deceased alive on April 20, 1960 , and that death occurred at 6:05 AM from the causes and on the date stated above.							
22a. SIGNATURE John D. Talbert, M.D.				22b. DATE SIGNED 4/20/60			
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D.				22d. ADDRESS VAH, BALTO. 18, MD. FT. HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 25-60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Fink Funeral Home				25a. REC'D BY REGISTRAR APR 25 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

0113

CERTIFICATE OF DEATH

0113



Place of Birth

Age

Sex

Date of Birth

Place of Death

Time of Death

Place of Death

Cause of Death

Place of Death

Sex

Age

Place of Birth

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Place of Birth

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U.S.A.

Place of Birth

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Place of Birth

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4236 CERTIFICATE OF DEATH

64160

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Howard		c. LENGTH OF STAY IN 1b 1 Day	
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore(17)	
		d. STREET ADDRESS 750 Reservoir Street	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First BERNARD Middle RUSSELL Last AQUILLA		4. DATE OF DEATH Month April Day 4 Year 1960	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 13, 1900
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months 60 Days 18 Hours 18 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction Co.	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Allen O. Aquilla		14. MOTHER'S MAIDEN NAME Ellen C. Bird	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. WW I 216-09-8992	17. INFORMANT Clinical Records, VAH, Balt 9. Md. Fort Howard Div.
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.0 DUE TO ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROSIS, MARKED, GENERALIZED (c)		INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN UNKNOWN
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (a) (this hospital) attended the deceased from **April 3, 1960** to **April 4, 1960** that we last saw the deceased **April 4, 1960** and that death occurred at **11:10AM** from the causes and on the date stated above.

22a. SIGNATURE Caridad E. Gonzalez	M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 4/5/60
22c. PHYSICIAN'S NAME (Type) CARIDAD E. GONZALEZ, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD. FORT HOWARD DIVISION

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/8/60	23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.	23d. LOCATION (City, town, or county) (State) Baltimore Maryland
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24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips	ADDRESS 1808 N. Monroe St. Balto. 17 Md.	25a. REC'D BY REGISTRAR APR 12 60	25b. REGISTRAR'S SIGNATURE Caridad E. Gonzalez
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420.1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other certificate is necessary, please execute it in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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5M 9/55

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64161

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)		c. LENGTH OF STAY IN 1b 8 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk (22)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2115 Dundalk Avenue				d. STREET ADDRESS 2115 Dundalk Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle ELLEN Last AYERS				4. DATE OF DEATH Month April Day 20th , Year 1960			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 23, 1959	
9. AGE (In years last birthday) yrs. 8		IF UNDER 1 YEAR Months 8 Days Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Lawrence Ayers				14. MOTHER'S MAIDEN NAME Helen Jager			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT J.L.Ayers		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 493X pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 1 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Jack C. Collins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/20/60	
EXAMINER'S NAME (Type) Jack C. Collins, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/22/60		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley				ADDRESS Dundalk 22, Md.		24a. REC'D BY REGISTRAR DATE APR 25 '60	
						24b. REGISTRAR'S SIGNATURE Arthur J. Kane	

2037242XV5

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1913 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]	
AGE [REDACTED]		DATE OF BIRTH [REDACTED]	
PLACE OF BIRTH [REDACTED]		OCCUPATION [REDACTED]	
RESIDENCE [REDACTED]		STREET ADDRESS [REDACTED]	
CITY [REDACTED]		STATE [REDACTED]	
COUNTY [REDACTED]		ZIP CODE [REDACTED]	
MARITAL STATUS [REDACTED]		CAUSE OF DEATH [REDACTED]	
MANNER OF DEATH [REDACTED]		SIGNATURE OF EXAMINER [REDACTED]	
DATE OF EXAMINATION [REDACTED]		TIME OF EXAMINATION [REDACTED]	
PLACE OF EXAMINATION [REDACTED]		SIGNATURE OF WITNESS [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]	
PLACE OF DEATH [REDACTED]		SIGNATURE OF DECEASED [REDACTED]	
DATE OF INTERMENT [REDACTED]		TIME OF INTERMENT [REDACTED]	
PLACE OF INTERMENT [REDACTED]		SIGNATURE OF INTERMENT AGENT [REDACTED]	
DATE OF BURIAL [REDACTED]		TIME OF BURIAL [REDACTED]	
PLACE OF BURIAL [REDACTED]		SIGNATURE OF BURIAL AGENT [REDACTED]	

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4222

CERTIFICATE OF DEATH

64162

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5/Lansdowne	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1723 Hall Ave		d. STREET ADDRESS 1723 Hall Ave.	

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Thomas Emory Barton Sr. First Middle Last			4. DATE OF DEATH April 25, 1960 Month Day Year		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1865	9. AGE (In years last birthday) 95 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired carpenter			10b. KIND OF BUSINESS OR INDUSTRY Balto. Co., Md.		12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME John M. Barton		14. MOTHER'S MAIDEN NAME Virginia Niehoff	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) none		16. SOCIAL SECURITY NO. none	

INFORMANT **John M. Barton** **338 Fifth Ave. Lansdowne Md**
Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		

21. I certify that I attended the deceased from 7/1 , 19 57 , to 4/25 , 19 60 , that I last saw the deceased alive on 4/25 , 19 60 , and that death occurred at 5:30 P.M., from the causes and on the date stated above.		DATE SIGNED 4/26/60
ACTUAL SIGNATURE J. N. Fredericks M.D. 1305 Francis Ave		ADDRESS (Street, city or town, state)
PHYSICIAN'S NAME (Type) J. N. Fredericks MD Balto. 27, Md		

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/28/60	22c. NAME OF CEMETERY OR CREMATORY Loudon Park	22d. LOCATION (City, town, or county) (State) Baltimore, Md
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard 4107 Wilkens Ave.		24a. REC'D BY REGISTRAR APR 28 '60	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Baltimore

Lanham

1703 Hall Ave

THOMAS EMORY TAYLOR JR.

Male White

Resident Carpenter

John M. Barton

None

None

Baltimore

Lanham

1703 Hall Ave

APRIL 25, 1960

Oct. 25, 1905

Baltimore, Md.

Virginia Nichols

John M. Barton 358 Fifth Ave. Lanham Md

Burial 4/25/60 - London Park

Howard H. Hubbard 6107 Wilkenn Ave.

Baltimore, Md.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4237 CERTIFICATE OF DEATH

05389

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 26 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
f. STREET ADDRESS 1103 WEST SARATOGA STREET				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BENJAMIN Middle H Last BATES				4. DATE OF DEATH Month APRIL Day 30 Year 1960			
5. SEX MALE		6. COLOR OR RACE COLORED		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 30, 1893	
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER				10b. KIND OF BUSINESS OR INDUSTRY RAILROAD			
11. BIRTHPLACE (State or foreign country) VIRGINIA				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME LEONARD BATES				14. MOTHER'S MAIDEN NAME SUSAN GAINES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO. WW-1			
17. INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIVISION				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PROSTATIC CARCINOMA WITH METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) RECTAL CARCINOMA DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH ? 3 MONTHS ? 3 MONTHS							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ANEMIA; CYSTITIS.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 4, 1960 to April 30, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 30, 1960 , and that death occurred 12:30am from the causes and on the date stated above.							
22a. SIGNATURE <i>Daniel A. Nieves</i> DANIEL A NIEVES				22b. DATE SIGNED 4-30-60			
22c. PHYSICIAN'S NAME (Type) DANIEL A NIEVES				22d. ADDRESS M.D. VAH Baltimore Md - Ft Howard Division			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5-4-60			
23c. NAME OF CEMETERY OR CREMATORY Baltimore National				23d. LOCATION (City, town, or county) (State) Baltimore Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Charles G Cooper</i> Charles G Cooper Funeral Home				25a. REC'D BY REGISTRAR DATE MAY 6 '60			
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Huns</i>				25c. ADDRESS 512 N Carrollton Ave Baltimore 23 Md			

MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4231 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64163

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Restonstown		c. LENGTH OF STAY IN 1b In Transit	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Oshorn Lane		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown R.D.1 06X-2	
3. NAME OF DECEASED (Type or print) First Middle Last Francenia Edna Becker		4. DATE OF DEATH Month Day Year April 17, 1960 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/9/1919
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 40	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert J. Sites		14. MOTHER'S MAIDEN NAME Lydia Belle Gardner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Oscar L. Becker, Taneytown, Md. R.D.1		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull - Crushed chest DUE TO Septic. Traumatic Amputation of L. Arm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Brain - Car accident (c) Train - Car accident PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		INTERVAL BETWEEN ONSET AND DEATH 5 min.	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car struck by train at crossing	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. Apr 17 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street - Rail Rd.		20f. (City or town) (County) (State) Restonstown Bkth. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R. D. Caples		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) D. D. CAPLES		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 21/60	
22c. NAME OF CEMETERY OR CREMATORY York Road Cemetery		22d. LOCATION (City, town, or county) (State) Nr. Hanover, York, Co. Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little		ADDRESS Richard A. Little, Littlestown, Pa.	
24a. REC'D BY REGISTRAR APR 20 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Rouse	

4113

6301 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED John Doe		2. SEX Male	
3. AGE 45		4. RACE White	
5. DATE OF DEATH Jan 15, 1920		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural	
9. SIGNATURE OF EXAMINER [Signature]		10. DATE Jan 15, 1920	
11. SIGNATURE OF WITNESSES [Signatures]		12. SIGNATURE OF CORONER [Signature]	
13. SIGNATURE OF JURY [Signatures]		14. SIGNATURE OF JUDGE [Signature]	
15. SIGNATURE OF CLERK [Signature]		16. SIGNATURE OF SHERIFF [Signature]	
17. SIGNATURE OF DISTRICT ATTORNEY [Signature]		18. SIGNATURE OF COUNTY CLERK [Signature]	
19. SIGNATURE OF TOWNSHIP CLERK [Signature]		20. SIGNATURE OF VILLAGE CLERK [Signature]	
21. SIGNATURE OF CITY CLERK [Signature]		22. SIGNATURE OF STATE CLERK [Signature]	
23. SIGNATURE OF FEDERAL CLERK [Signature]		24. SIGNATURE OF NATIONAL CLERK [Signature]	
25. SIGNATURE OF INTERNATIONAL CLERK [Signature]		26. SIGNATURE OF UNIVERSAL CLERK [Signature]	
27. SIGNATURE OF COSMOPOLITAN CLERK [Signature]		28. SIGNATURE OF GALACTIC CLERK [Signature]	
29. SIGNATURE OF PLANETARY CLERK [Signature]		30. SIGNATURE OF SOLAR CLERK [Signature]	
31. SIGNATURE OF LUNAR CLERK [Signature]		32. SIGNATURE OF STELLAR CLERK [Signature]	
33. SIGNATURE OF COSMIC CLERK [Signature]		34. SIGNATURE OF UNIVERSE CLERK [Signature]	
35. SIGNATURE OF OMNIPOTENT CLERK [Signature]		36. SIGNATURE OF OMNISCIENT CLERK [Signature]	
37. SIGNATURE OF OMNIBENEFICENT CLERK [Signature]		38. SIGNATURE OF OMNIPRESENT CLERK [Signature]	
39. SIGNATURE OF OMNIPOTENT OMNISCIENT OMNIBENEFICENT OMNIPRESENT CLERK [Signature]		40. SIGNATURE OF OMNIPOTENT OMNISCIENT OMNIBENEFICENT OMNIPRESENT CLERK [Signature]	



THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE COUNTY OF [] STATE OF []

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4238 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04164

1. PLACE OF DEATH a. COUNTY <u>TOWSON Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 TOWNSON</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>14 LENNOX AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>WESLEY</u> Last <u>BLAKE</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>4</u> Year <u>19 60</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR. 29, 1868</u>	
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>messenger</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Eastern Shore, Md.</u>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Percy Blake</u>				14. MOTHER'S MAIDEN NAME <u>Liza</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>maude bapkins</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4/4/60</u>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/4/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Rest</u>		22d. LOCATION (City, town, or county) (State) <u>Towson Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Earl Gilmore - 519 Mosher St</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR DATE <u>APR 11 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kane</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4239 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **4165**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 6mth11dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS none		17X-2	
3. NAME OF DECEASED (Type or print) First William Middle Adolphus Last Bland				4. DATE OF DEATH Month 4 Day 8 Year 1960			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 8, 1883		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 212-16-1286		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure 936.7 DUE TO Conditions, if any, which gave rise to immediate cause (b) Pneumonia, Cardiovascular disease (c) fracture left hip accident PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) On 2-10-60 reduction and Steinmann pinning was performed							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) On 1-24-60 patient was found with laceration over the left eye and frac. left hip; cause unknown		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year 7:45 P.M. 1-24-60		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Catonsville 28, Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Geo M Kieffer M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) George M. Kieffer, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/11/60		22c. NAME OF CEMETERY OR CREMATORY Church Hill		22d. LOCATION (City, town, or county) (State) Church Hill Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane				ADDRESS Church Hill Md.		24a. REC'D BY REGISTRAR APR 13 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1 ** 5*
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
4240
CERTIFICATE OF DEATH
04166

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonville</i> c. LENGTH OF STAY IN 1b <i>53</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>House in Pines</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Balto.</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonville</i> d. STREET ADDRESS <i>Catonville High School</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>William L. Boggs</i> First Middle Last		4. DATE OF DEATH <i>April 18 1960</i> Month Day Year	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/26/94</i> yrs.
9. AGE (In years last birthday) <i>66</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher Balt. Co. Schools</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>S. C.</i>	
11. BIRTHPLACE (State or foreign country) <i>U. S. A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>unknown to informant</i>		14. MOTHER'S MAIDEN NAME <i>unknown to informant</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes WWI NAVY</i>		16. SOCIAL SECURITY NO. <i>Howard Griffin</i>	
17. INFORMANT <i>Howard Griffin</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO <i>Chronic Hypertensive Cardio-Vascular Disease</i> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) <i>Chronic Hypertensive Cardio-Vascular Disease</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>13 da.</i> <i>3 yr.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>3-3-</i> 1957 to <i>4-18-</i> 1960, that (I) (we) last saw the deceased alive on <i>4-16-</i> 1960, and that death occurred at <i>7:00</i> A.M., from the causes and on the date stated above.			
22a. SIGNATURE <i>Wilmer K. Gallagher</i> M.D.		22b. DATE SIGNED <i>4/21/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>Wilmer K. Gallagher M.D.</i>		22d. ADDRESS <i>6209 Frederick Ave., Balt. 28, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4/22/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Balto. National</i>		23d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Sam Stubb & Son Co.</i>		25. REC'D BY REGISTRAR <i>28</i>	
ADDRESS <i>28</i>		25b. REGISTRAR'S SIGNATURE <i>Clara L. Kline</i>	
DATE <i>APR 22 '60</i>			

03110

CERTIFICATE OF DEATH

0330

DECEASED

1

1

NEW YORK

1901

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4214

CERTIFICATE OF DEATH

64167

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1726 Langport Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle SYLVAN Last BOHLE				4. DATE OF DEATH Month April Day 14 Year 19 60			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 23, 1892	
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none - retired				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) York, Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Frank Anthony Bohle				14. MOTHER'S MAIDEN NAME Katherine M. Huppman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Margaret Wilhelm Bohle, wife, above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 501X DUE TO Asthmatic bronchitis - pulmonary Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) emphysema & fibrosis (c) 2 weeks 25 years						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan. 1959 to April 1960 , that I last saw the deceased alive on 12 April 1960 , and that death occurred at 11:20 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE B. W. Sollard, M.D.				ADDRESS (Street, city or town, state) 2900 Dunbar Rd Baltimore, Md.			
DATE SIGNED 4-16-60							
PHYSICIAN'S NAME (Type) B. W. Sollard, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/19/60		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek ADDRESS 2601-3-5 E. Madison St.				24a. REC'D BY REGISTRAR DATE APR 20 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

172

NAME OF DECEASED JOHN SILVER HORNE		DATE OF BIRTH April 12, 1900	
RESIDENCE 1720 Lombard Avenue		PLACE OF BIRTH Baltimore, Md.	
SEX Male		RACE White	
DATE OF DEATH April 12, 1900		PLACE OF DEATH Baltimore, Md.	
CAUSE OF DEATH Heart failure		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN Katherine M. Hughes		SIGNATURE OF WITNESSES Katherine M. Hughes	
SIGNATURE OF DECEASED John Silver Horne		SIGNATURE OF SURVIVORS Katherine M. Hughes	
SIGNATURE OF REGISTRAR Katherine M. Hughes		SIGNATURE OF CLERK Katherine M. Hughes	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EDGEWATER		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EDGEWATER	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2149 GRAYTHORN RD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JEAN Middle C. Last BOLCH.		4. DATE OF DEATH Month APRIL Day 16 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH MAY 27, 1916
9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR Months 14 Days 7 Hours 18 Min.	11. IF UNDER 24 HRS. Months 14 Days 7 Hours 18 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL TEACHER		10b. KIND OF BUSINESS OR INDUSTRY SCHOOL TEACHER	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CLYDE CHADDOCK.		14. MOTHER'S MAIDEN NAME HELEN SCOTHERN.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 232-20-9090.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis DUE TO Malignancy of Spine Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Fundus of Uterus DUE TO (c) 18 months		INTERVAL BETWEEN ONSET AND DEATH 14 months 7 months 18 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October , 19 58 , to Apr 16 , 19 60 , that I last saw the deceased alive on Apr 16 , 19 60 , and that death occurred at 7:30 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Morris A. Jacobs		ADDRESS (Street, city or town, state) 1010 NORTH Point Road Baltimore 24 Md	
PHYSICIAN'S NAME (Type) MORRIS A. Jacobs		DATE SIGNED 4/16/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF APRIL 19, 1960	22c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH	22d. LOCATION (City, town, or county) (State) FULLESTON MD.
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home 7401 Belair Rd. #6 Md		24a. REC'D BY REGISTRAR APR 21 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

State of Michigan
County of Wayne
City of Detroit
I, the undersigned, being a duly qualified physician, do hereby certify that
on the 12th day of April, 1902, at the City of Detroit, Michigan,
I attended the last illness of
John A. Smith
aged 45 years
who died at his residence, No. 1234 East Warren Street,
at 10 o'clock, P. M.
The cause of death was
Myocardial Infarction
The death was
Natural
The body was
Examined and found
To be
In good health
Except for the above mentioned condition
The death was
Not
Due to
Any
Other
Cause
Than
That
Stated
Above
I, the undersigned, being a duly qualified physician, do hereby certify that
on the 12th day of April, 1902, at the City of Detroit, Michigan,
I attended the last illness of
John A. Smith
aged 45 years
who died at his residence, No. 1234 East Warren Street,
at 10 o'clock, P. M.
The cause of death was
Myocardial Infarction
The death was
Natural
The body was
Examined and found
To be
In good health
Except for the above mentioned condition
The death was
Not
Due to
Any
Other
Cause
Than
That
Stated
Above

CERTIFICATE OF DEATH

4169

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOSEPHINE</u> First Middle Last		4. DATE OF DEATH <u>4/10/60</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/11/1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Geo. Dresh</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Kober</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Embolism</u> 420.1 DUE TO <u>Cardio-Vascular Renal Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiac Decompensation</u> (c) <u>4 months</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs.?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1.21</u> , 19 <u>58</u> , to <u>4.10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4.8</u> , 19 <u>60</u> , and that death occurred at <u>8:09</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George E. Urban</u>		ADDRESS (Street, city or town, state) <u>805 S. Drick Ave 28</u>	
PHYSICIAN'S NAME (Type) <u>George E. URBAN</u>		DATE SIGNED <u>4.10.60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/13/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	22d. LOCATION (City, town, or county) (State) <u>Bellair Road</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Fahy & Sons</u>		24a. REC'D BY REGISTRAR <u>APR 14 '60</u>	
ADDRESS <u>1318 Legat</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

434.4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film G261 4/28/60 iwk

4243

CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH a. COUNTY <u>Balto 19</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>as in</u> b. COUNTY <u>#1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharrows Pt</u>				c. LENGTH OF STAY IN 1b <u>3 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2405 RUTH AVE</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EMMA J. BROWN</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>20</u> Year <u>1960</u>			
5. SEX <u>FEM.</u>	6. COLOR OR RACE <u>COL.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 24 1902</u>		9. AGE (In years last birthday) <u>57</u> yrs.	10. IF UNDER 1 YEAR Months <u>57</u> Days <u>57</u> Hours <u>57</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Lucas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Mary Newby - as in #1</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive - arteriosclerotic C.V. disease</u> DUE TO (c) <u>stroke</u>						INTERVAL BETWEEN ONSET AND DEATH <u>20 days</u> <u>7 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1, 1960</u> to <u>April 20, 1960</u> , that I last saw the deceased alive on <u>April 19, 1960</u> , and that death occurred at <u>S.A.L.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Louis N. Tollin</u> M.D.				ADDRESS (Street) city or town, state <u>6908 N. POINT Rd.</u>		DATE SIGNED <u>4/20/60</u>	
PHYSICIAN'S NAME (Type) <u>LOUIS N. TOLLIN</u>				<u>BALTIMORE-19- MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-23-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. CALVARY</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles F. Law - 802 Madison Ave.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4244

CERTIFICATE OF DEATH

64172
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN TB 52 Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Douglas Memorial Home		d. STREET ADDRESS 5921 Frederick Road	
3. NAME OF DECEASED (Type or print) JOSEPH NMI BROWN		4. DATE OF DEATH Month Apr. Day 23 Year 1960	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1881
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Building	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unk.	
14. MOTHER'S MAIDEN NAME Unk.		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Records: Douglas Memorial Home 5921 Frederick Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive-Arterio-sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive-Arterio-sclerosis			INTERVAL BETWEEN ONSET AND DEATH 7 Days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4-16-60 , 19 60 , to 4-23-60 , 19 60 , that I last saw the deceased alive on 4-23-60 , 19 60 , and that death occurred at 5:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 57 Winters Lane -28 DATE SIGNED 4-23-60			
ACTUAL SIGNATURE C. F. Maloney M.D.		PHYSICIAN'S NAME (Type) C. F. Maloney, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/26/1960	22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn
22d. LOCATION (City, town, or county) (State) Balto, Md.		23. FUNERAL DIRECTOR'S SIGNATURE Holland Funeral Home 1631 Druid Hill Ave.	
24a. REC'D BY REGISTRAR APR 27 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 15 1880		New York City	
Cause of Death		Disease		Symptoms		Duration		Time of Day	
Heart Disease		Coronary Artery Disease		Chest Pain, Shortness of Breath		2 Weeks		10:00 AM	
Occupation		Education		Marital Status		Religion		Usual Residence	
Teacher		High School		Married		Catholic		123 Main St, Baltimore	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Death		Place of Death		Manner of Death		Certified True and Correct		By Registrar	
Jan 20 1925		Home		Natural		[Initials]		[Initials]	

DEATH CERTIFICATE
FURNISHED BY THE
STATE DEPARTMENT OF HEALTH
BALTIMORE, MARYLAND

1 **CERTIFICATE OF DEATH**
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
4245

64173

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 34 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WEBB Middle F. Last BROWN				4. DATE OF DEATH Month APRIL Day 1 Year 19 60			
5. SEX MALE		6. COLOR OR RACE COLORED		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 16, 1889	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JANITOR (RETIRED)				11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN BROWN				14. MOTHER'S MAIDEN NAME GRACE WILLIAMS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW-1				16. SOCIAL SECURITY NO. 216-18-0932			
17. INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIVISION				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY INFARCTION OF THE RIGHT LUNG 464X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) THROMBOPHLEBITIS OF LEFT FEMORAL VEIN DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 4 DAYS 1 WEEK
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) AORTITIS, CHRONIC							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that he (this hospital) attended the deceased from February 27, 19 60 to April 1, 19 60 that he (we) last saw the deceased alive on April 1, 19 60 , and that death occurred at 4:55 pm from the causes and on the date stated above.							
22a. SIGNATURE				22b. DATE SIGNED 4-2-60			
22c. PHYSICIAN'S NAME (Type) Clyde B. Cope				22d. ADDRESS M.D. VAH, Baltimore, Md.-Ft. Howard Division			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4-6-60			
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL				23d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips				25a. REC'D BY REGISTRAR APR 12 '60			
ADDRESS 1808-10 N. Monroe St Baltimore 17, Md.				25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

CERTIFICATE OF DEATH

DATE OF DEATH: JUNE 10, 1959
PLACE OF DEATH: HOME
AGE: 70
SEX: M
RACE: W
BIRTH: JUNE 10, 1959
TO: JUNE 10, 1959

DEATH: JUNE 10, 1959

CAUSE OF DEATH

DEATH: JUNE 10, 1959

DEATH: JUNE 10, 1959

DEATH: JUNE 10, 1959

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DEATH: JUNE 10, 1959

DEATH: JUNE 10, 1959

4246

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Martina Middle A. Last Bryan		4. DATE OF DEATH Month April Day 25 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 30, 1874
9. AGE (In years lost birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 3 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) hospital worker		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Alfred Thomas Bryan		14. MOTHER'S MAIDEN NAME Emily Higgins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 9, 1960 to April 25, 1960 , that I last saw the deceased alive on April 25, 1960 , and that death occurred at 9:30 a.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE Bruno Radauskas		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL 4-25-60	
PHYSICIAN'S NAME (Type) BRUNO RADAUSKAS		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	28 April 1960	New Cathedral	Balto Md
23. FUNERAL DIRECTOR'S SIGNATURE Arthur E. Walters		24a. REC'D BY REGISTRAR DATE APR 27 '60	
ADDRESS 1414 E. Walters		24b. REGISTRAR'S SIGNATURE Arthur E. Walters	

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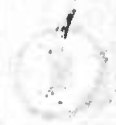
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

01114
BIO
CIVILIAN
CIVILIAN

CERTIFICATE
1948



[Faint, mostly illegible text and lines, likely a form or certificate body.]



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
4247 **CERTIFICATE OF DEATH** 04175

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 131 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRANCIS Middle E. Last BURTON				4. DATE OF DEATH Month APRIL Day 9 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/19/13	
9. AGE (In years lost birthday) 46 yrs.		10. IF UNDER 1 YEAR Months 6 Days 1 Hours 1 Min.		11. IF UNDER 24 HRS. Months 6 Days 1 Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer				10b. KIND OF BUSINESS OR INDUSTRY Brewery		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Robert R. Burton				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 218-05-0051		17. INFORMANT Clin. Rec. VAH, Balto. Md. Ft. Howard Division	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LAENNEC'S CIRRHOSIS WITH JAUNDICE AND ASCITES 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 6 Months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that W (this hospital) attended the deceased from Nov. 30 19 59 to April 9 19 60 , that W (we) lost saw the deceased alive on April 9 19 60 , and that death occurred at 7:18 AM from the causes and on the date stated above.							
22a. SIGNATURE Charles Allen, M.D.				22b. DATE SIGNED 4/9/60			
22c. PHYSICIAN'S NAME (Type) CHARLES ALLEN, M.D.				22d. ADDRESS VAH, BALTO., MD. FORT HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 13/60		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir.				25a. REC'D BY REGISTRAR DATE APR 12 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 4248 CERTIFICATE OF DEATH

64176

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE				c. LENGTH OF STAY IN 1b 4 MONTHS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CLARENCE Middle H Last BUTTON				4. DATE OF DEATH Month APRIL Day 3 Year 1960			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 18, 1881	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATCH MAN				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME WILLIAM H. BUTTON				14. MOTHER'S MAIDEN NAME ANGELINE MCCANN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Frank L. Smith Jr. Cockeysville Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Arterio Sclerotic Cardio 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Vascular Disease. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-9-1927 to 4-1-1960 , that (I) (we) last saw the deceased alive on 4-1-1960 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Walter T. Kees				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/3/60.	
22c. PHYSICIAN'S NAME (Type) WALTER T. KEES				22d. ADDRESS COCKEYSVILLE MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-6-60		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial		23d. LOCATION (City, town, or county) (State) Taylor Ave & Dalesford Road	
24. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc. 1217 St. Paul Street				25a. REC'D BY REGISTRAR DATE APR 6 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kram	

10110

CERTIFICATE OF DEATH

1911-1912

1911-1912

1911-1912

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore County</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Mt. Wilson, Maryland</u>		<u>40 days</u>		TOWN <u>Frostburg</u>		<u>01222</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>				STREET ADDRESS (If rural, give location) <u>191 E Main St.</u>			
3. NAME OF DECEASED (Type or Print) <u>Patrick Francis Cavanaugh</u>				4. DATE OF DEATH (Month) <u>4</u> (Day) <u>16</u> (Year) <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>4/1/1899</u>	9. AGE last birthday <u>61</u> yrs.		IF UNDER 1 YEAR (Month) (Day) (Year) IF UNDER 24 HRS. (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if railroad) <u>Tire builder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Kelly-Sp Tire Co</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Patrick F. Cavanaugh</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth T. Atkinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-07-0030</u>		17. INFORMANT & ADDRESS <u>Hosp. Records, Mt. Wilson State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>163x Carcinoma of Lung</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 month</u>			
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/7</u> , 19 <u>60</u> , to <u>4/16</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/16</u> , 19 <u>60</u> , and that death occurred at <u>9:35 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William Newcomer</u>				ADDRESS (Street, city, town, state) <u>M.D. Superintendent, Mt. Wilson, Md.</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-19-60</u>		NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frostburg Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James E. Hunter</u>		ADDRESS <u>Home</u>	
DATE <u>Apr 20 '60</u>							

CERTIFICATE OF DEATH

Reg. No. 14

1. Name of deceased (Print or write)

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Usual residence

7. Cause of death

8. Date of death

9. Time of death

10. Place of death

11. Signature of physician

12. Signature of registrar

13. Signature of informant

14. Signature of witness

15. Signature of funeral director

16. Signature of undertaker

17. Signature of cemetery

18. Signature of burial

19. Signature of interment

20. Signature of record

21. Signature of office

22. Signature of department

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

64178

4215

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PATAPSCO RIVER NR. HARBOR FIELD</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 DUNDALK (22)</u> d. STREET ADDRESS <u>320 YORKWAY</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EUGENE (NM) CLEMONS</u>		4. DATE OF DEATH Month Day Year <u>4/9/1960</u> 19 <u>60</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>OCT 28, 1946</u> 9. AGE (In years last birthday) <u>13</u> yrs. IF UNDER 1 YEAR Months <u>4</u> Days <u>9</u> IF UNDER 24 HRS. Hours <u>13</u> Min. <u>00</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>CURTIS CLEMONS</u> 14. MOTHER'S MAIDEN NAME <u>VERSIE HOWERTON CLEMONS</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT Address <u>CURTIS CLEMONS - FATHER - 2 ABOVE</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNING</u> <u>850X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>—</u> (c), stating the underlying cause last. DUE TO <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell from home-made rope while fishing.</u>		20c. TIME OF INJURY Month, Day, Year <u>4-9-60</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>PATAPSCO RIVER</u> (City or town) <u>Dundalk</u> (County) <u>BALTO.</u> (State) <u>MD</u>					
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Melvin B. Davis, M.D.</u> EXAMINER'S NAME (Type) <u>Melvin B. Davis, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>4/11/60.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>4/12/1960</u> 22c. NAME OF CEMETERY OR CREMATORY <u>BALTO. NATIONAL</u> 22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Thomas</u> ADDRESS <u>4111 Yorkway, Dundalk, Md.</u> 24a. REC'D BY REGISTRAR <u>APR 13 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any doubt is necessary, please execute in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9298

NAME OF DECEASED _____		SEX _____		AGE _____	
PLACE OF BIRTH _____		OCCUPATION _____		DATE OF DEATH _____	
TIME OF DEATH _____		PLACE OF DEATH _____		CAUSE OF DEATH _____	
MANNER OF DEATH _____		MEDICAL HISTORY _____		PRESENT ILLNESS _____	
SIGNATURE OF MEDICAL EXAMINER _____		SIGNATURE OF ATTENDING PHYSICIAN _____		SIGNATURE OF CORONER _____	
CITY _____		COUNTY _____		STATE _____	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4250

CERTIFICATE OF DEATH

Reg. Dist. No.

64179

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - WOODLAWN</u>		c. LENGTH OF STAY IN 1b <u>12 YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BOX #208 DOGWOOD RD.</u>		d. STREET ADDRESS <u>BOX #208 DOGWOOD ROAD</u>	
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>FLORENCE</u> Last <u>COMPTON</u>		4. DATE OF DEATH Month <u>4</u> Day <u>10</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/13/79</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM BUTLER</u>		14. MOTHER'S MAIDEN NAME <u>MARY HAY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>IDA G. BAUBLITZ - DAUGHTER</u>		Address <u>6805 CHIPPEWADD BALTO. 9.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DEGENERATIVE HEART DISEASE</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>ONE WEEK</u> <u>10 YEARS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/12</u> , 19 <u>53</u> , to <u>4/10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/9</u> , 19 <u>60</u> , and that death occurred at <u>4:08</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edwin L. Pierpont</u> M.D.		ADDRESS (Street, city or town, state) <u>2204 LIBERTY RD, BALTO. 7, MD</u>	
PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT, M.D.</u>		DATE SIGNED <u>4/10/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>APRIL 13, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MOUNT OLIVE</u>	22d. LOCATION (City, town, or county) (State) <u>RANDALLSTOWN, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gaston Sowa</u> ADDRESS <u>CATONSVILLE, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 13 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles B. Kuntz</u>	

CERTIFICATE OF DEATH

4250

434.4

<p>1. Name of deceased (Print name and surname) JAMES EARL RAY</p>		<p>2. Sex Male</p>	
<p>3. Date of birth 10-14-1928</p>		<p>4. Place of birth MOBILE, ALABAMA</p>	
<p>5. Date of death 4-4-1968</p>		<p>6. Place of death MOBILE, ALABAMA</p>	
<p>7. Cause of death (State immediately and briefly) HEART DISEASE</p>		<p>8. Nature of disease (State fully) CORONARY ARTERY DISEASE</p>	
<p>9. Duration of illness (State fully) 2-3 months</p>		<p>10. Name of physician (Print name and surname) DR. J. H. HARRIS</p>	
<p>11. Name of funeral home (Print name and surname) J. H. HARRIS</p>		<p>12. Name of undertaker (Print name and surname) J. H. HARRIS</p>	
<p>13. Name of cemetery (Print name and surname) J. H. HARRIS</p>		<p>14. Name of burial place (Print name and surname) J. H. HARRIS</p>	
<p>15. Name of next of kin (Print name and surname) J. H. HARRIS</p>		<p>16. Name of informant (Print name and surname) J. H. HARRIS</p>	
<p>17. Name of registrar (Print name and surname) J. H. HARRIS</p>		<p>18. Name of official (Print name and surname) J. H. HARRIS</p>	

1. This certificate is to be filled out by the physician or other person who has attended the deceased during his illness or at the time of death.
 2. The cause of death should be stated in full, and the nature of the disease should be stated in full.
 3. The duration of the illness should be stated in full.
 4. The name of the physician should be stated in full.
 5. The name of the funeral home should be stated in full.
 6. The name of the undertaker should be stated in full.
 7. The name of the cemetery should be stated in full.
 8. The name of the burial place should be stated in full.
 9. The name of the next of kin should be stated in full.
 10. The name of the informant should be stated in full.
 11. The name of the registrar should be stated in full.
 12. The name of the official should be stated in full.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
4251
CERTIFICATE OF DEATH

64180

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 96 Days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (19)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 2114 Lodge Forest Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle M. Last CONRAD		4. DATE OF DEATH Month April Day 15 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 31, 1895
9. AGE (In years lost birthday) 65		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Layer		10b. KIND OF BUSINESS OR INDUSTRY Steel Company	
11. BIRTHPLACE (State or foreign country) Chapel, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Gustav Conrad		14. MOTHER'S MAIDEN NAME Susie Kissinger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 213-09-4172	
17. INFORMANT Clin. Rec. VAH, Baltimore 18, Md. Fort Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, LEFT 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) EMPHYEMA, RIGHT, OLD (c) PULMONARY HEART DISEASE, OLD PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Surgical abscess, right lung, old. Metastatic Carcinoma, bone L4&L5, old			
INTERVAL BETWEEN ONSET AND DEATH RECENT			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 1, 1960 , to April 15, 1960 , that (I) (we) last saw the deceased alive on April 15, 1960 , and that death occurred at 2:10 AM on the causes and on the date stated above.			
22a. SIGNATURE Caridad E. Gonzalez		22b. DATE SIGNED 4/15/60	
22c. PHYSICIAN'S NAME (Type) CARIDAD E. GONZALEZ, M.D.		22d. ADDRESS VAH, BALTO. 18, MD. FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/18/60	
23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ulrich		25a. REC'D BY REGISTRAR APR 20 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kruus			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban poppers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
4252
CERTIFICATE OF DEATH

64181

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>52</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Mary's Hosp. Home</u>		e. STREET ADDRESS <u>Lungersie Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Carrie Verna Davis</u>		4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 21, 1887</u>
9. AGE (In years lost birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>3</u> Hours <u>15</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry S. Charles</u>		14. MOTHER'S MAIDEN NAME <u>Louise Jenkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Thomas Lee Davis</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis - Adenocarcinoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma ascending colon</u> DUE TO (c) <u>3 yrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> to <u>1960</u> , that (I) (we) last saw the deceased alive on <u>April 23, 1960</u> , and that death occurred at <u>12:15 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>C. Vernon Williamson</u>		22b. DATE SIGNED <u>—</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. VERNON WILLIAMSON</u>		22d. ADDRESS <u>4508 Edmondson Village (29)</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/26/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Maithydon</u>		ADDRESS <u>28</u>	
25a. REC'D BY REGISTRAR DATE <u>APR 27 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

1871

WEST VIRGINIA
DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH



[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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4253
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04182

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 52 Catonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) 429 Academy Road				d. STREET ADDRESS 429 Academy Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John J. Davis				4. DATE OF DEATH Month April Day 3 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 10/89	
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.		11. IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector				10b. KIND OF BUSINESS OR INDUSTRY Baltimore city		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Thomas E. Davis				14. MOTHER'S MAIDEN NAME Mary Haas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 214 40, 4492		17. INFORMANT Mrs. Ida Davis, 429 Academy Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Occlusion Coronary DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension				INTERVAL BETWEEN ONSET AND DEATH 3 hrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/15/54 to 4/3/60 that (I) (we) last saw the deceased alive on 4/3/60 and that death occurred at 3 PM , from the causes and on the date stated above.							
22a. SIGNATURE E. J. Mendelis				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/4/60	
22c. PHYSICIAN'S NAME (Type) E. J. Mendelis				22d. ADDRESS 651 N Bentaton St			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 6/60		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City, town, or county) (State) Baltimore 29, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D. 4101 Edmondson Ave.				25a. REC'D BY REGISTRAR DATE APR 5 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

4254
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Garrison</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Spurgeon David Davis</u>		4. DATE OF DEATH Month Day Year <u>4 4 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 26, 1888</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardener</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private</u>	
11. BIRTHPLACE (State or foreign country) <u>Garrison, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Janett Davis</u>		14. MOTHER'S MAIDEN NAME <u>Mary Alice Bell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>0</u>	
17. INFORMANT <u>Mrs. Alice Smith</u>		Address <u>Garrison, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C.V.D.</u> <u>422.1</u> DUE TO <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb-8</u> , 19 <u>60</u> , to <u>4-4</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3-31</u> , 19 <u>60</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles H. Williams</u> M.D.		ADDRESS (Street, city or town, state) <u>1632 Reisterstown Road</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Charles H. Williams</u>		<u>Pikesville 8, Md.</u>	
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-8-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Lukes Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Reisterstown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Frances A. Hensley</u>		ADDRESS <u>5780</u>	
24a. REC'D BY REGISTRAR <u>APR 5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>C. S. K...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4255

CERTIFICATE OF DEATH

Reg. Dist. No. 4184

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2701 Wildberger Avenue</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mrs. Margaret T. De Graw</i>				4. DATE OF DEATH Month Day Year <i>April 4th 1960</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan 1, 1879</i>	
9. AGE (In years lost birthday) <i>81</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <i>Hertford Co. N.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10c. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <i>George W. Britt</i>				14. MOTHER'S MAIDEN NAME <i>Margaret Butler</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>Mr. Elmer De Graw, 2701 Wildberger Ave.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.2</i> DUE TO <i>Degenerative heart disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <i>old age</i> (c)							INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1952</i> to <i>4</i> , 1960, that I last saw the deceased alive on <i>ag 2</i> , 1960, and that death occurred at <i>1:25 AM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Harold J. Burns</i> M.D.				ADDRESS (Street, city or town, state) <i>8106 Harford Rd.</i>		DATE SIGNED <i>4-4-60</i>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/6/60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>				ADDRESS <i>5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR DATE <i>APR 6 '60</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur L. Harris</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1234

1104



Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
4256 CERTIFICATE OF DEATH 64185

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harrison</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> 3V01.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>St. Leigh Nursing Home</i>		d. STREET ADDRESS <i>4409 Forest Park Ave.</i>	
3. NAME OF DECEASED (Type or print) First <i>Charles</i> Middle <i>Pickman</i> Last <i>Pickman</i>		4. DATE OF DEATH Month <i>4</i> Day <i>22</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/7/1901</i>
9. AGE (In years last birthday) <i>59</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Proprietor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Restaurant</i>	
11. BIRTHPLACE (State or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.C.</i>	
13. FATHER'S NAME <i>Solomon Pickman</i>		14. MOTHER'S MAIDEN NAME <i>Anna ?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>219-32-008</i>	
17. INFORMANT <i>Beatrice Pickman</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronch. Pneumonia</i> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Stroke - C.V.A. Cerebral Thrombus</i> DUE TO (c) <i>H. A. S. H. D.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>1 week</i> <i>57 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>11/7</i> 19 <i>59</i> , to <i>4/22</i> 19 <i>60</i> , that (I) (we) last saw the deceased alive on <i>4/22</i> 19 <i>60</i> , and that death occurred at <i>2308</i> PM, from the causes and on the date stated above.			
22a. SIGNATURE <i>Israhel Zinberg</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>ISRAEL ZINBERG</i>		22d. ADDRESS <i>2320 Entance Place</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4/24/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Beaumont</i>		23d. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Sol. L. Luman</i>		25a. REC'D BY REGISTRAR DATE <i>APR 26 '60</i>	
ADDRESS <i>6010 Forest Rd.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>	

CERTIFICATE OF DEATH

1922

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Blank certificate form with horizontal lines for text entry.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4257 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

64186

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills				c. LENGTH OF STAY IN 1b X Owings Mills			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 324 Pleasant Hill Rd.				/d. STREET ADDRESS 324 Pleasant Hill Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Adam Last Diehl Sr.				4. DATE OF DEATH Month April Day 3 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 5, 1899		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintainance man at Hospital			10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Adam Diehl			14. MOTHER'S MAIDEN NAME Rebecca Nace				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-20-9039		17. INFORMANT Mrs. Rosie Turnbaugh Address Reisterstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C-V Disease DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 1 yr. 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m. none		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE D. D. Caples				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) D. D. Caples, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		4-4-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/7/60		22c. NAME OF CEMETERY OR CREMATORY Reisterstown Methodist		22d. LOCATION (City, town, or county) (State) Reisterstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F.Eline & Sons				ADDRESS Reisterstown, Md.		24a. REC'D BY REGISTRAR APR 5 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO DEPARTMENT OF HEALTH: This certificate should be executed within 24 hours after death. If any certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
4258
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05421

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 26 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JEAN W. DIFFENDERFER Served As: JEAN N. WOOLWORTH		4. DATE OF DEATH Month APRIL Day 9 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/7/86
9. AGE (In years lost birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Christopher J. Hinricks		14. MOTHER'S MAIDEN NAME Ellen M. Bruehl	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I	
17. INFORMANT Clin. Rec. VAH, Balto. Md. Ft. Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CARDIAC ARRHYTHMIA 433.1 ARTERIOSCLEROTIC ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE WITH OLD HEALED POSTERIOR INFARCTION Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. ARTERIOSCLEROSIS GENERALIZED PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS. ARTERIOSCLEROSIS OBLITERANS RT. LEG WITH GANGRENE OF FOOT INTERVAL BETWEEN ONSET AND DEATH MINUTES 20 YEARS UNKNOWN			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 14 , 19 60 , to April 9 , 19 60 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 9 , 19 60 and that death occurred at 7:45 PM from the causes and on the date stated above.			
22a. SIGNATURE Arthur T. Faulk, MD		22b. DATE SIGNED 4/10/60	
22c. PHYSICIAN'S NAME (Type) ARTHUR T. FAULK, M.D.		22d. ADDRESS VAH, BALTO. MD. FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 4/13/60	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION (City, town, or county) (State) Bladensburg, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Frampton Carroll Undertakers		25a. REC'D BY REGISTRAR DATE MAY 23 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kneass			

1913

CERTIFICATE OF DEATH

1913

(14)

Full name of deceased
Age
Sex
Date of birth
Place of birth
Cause of death
Date of death
Place of death
Signature of physician
Signature of registrar
Date of registration
Place of registration

CERTIFICATE OF DEATH

Reg. Dist. No. **64187****4259**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 826 Scarlett Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mr. Paul Di Pino		4. DATE OF DEATH Month Day Year April 14th 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 3, 1882
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Italy	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Sebastian Di Pino		14. MOTHER'S MAIDEN NAME Josephine Bonica	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-05-2416	
17. INFORMANT Mrs. Jennie Di Pino		Address 826 Scarlett Drive.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 3327 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-7 , 19 60 , to 4-14 , 19 60 ; that I last saw the deceased alive on 4-13 , 19 60 , and that death occurred at 1:05 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Sebastian Russo M.D.		DATE SIGNED 5017 Harford Road	
PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO MD		5017 HARFORD ROAD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/18/60	22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		24a. REC'D BY REGISTRAR APR 18 '60	
ADDRESS 5305 Harford Road #14		24b. REGISTRAR'S SIGNATURE Arthur S. Ruck	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1924

1

1



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 4188										
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 1mth 4dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			3. Vol. 4		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL					d. STREET ADDRESS 6517 Vincennes Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Paul Middle Augusta Last Ditman					4. DATE OF DEATH Month April Day 1 Year 19 60					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 12, 1887		9. AGE (In years last birthday) 72 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Joshua Ditman					14. MOTHER'S MAIDEN NAME Hannah Gogrig					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-07-7458		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture Right Hip - Accident DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) or (b). On 3-17-60 reduction and internal fixation with Smith-Petersen nail and side plate was performed under spinal anesthesia. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pt. was found on 3-7-60 with pain in right hip. X-ray revealed intertrochanteric frac. of right femur - circumstances of injury unknown.							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 3-7 19 60			20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital		20f. (City or town) (County) (State) Catonsville 28, Maryland			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE George M. Kieffer					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) George M. Kieffer, M. D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 4/1/60		22c. NAME OF CEMETERY OR CREMATORY Lorraine Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Am. J. Tietener & Sons - Balto 17					24a. REC'D BY REGISTRAR DATE APR 4 '60		24b. REGISTRAR'S SIGNATURE Carlton S. Kraus			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4261 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenarm Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sister Mary Genevieve Dittmann		4. DATE OF DEATH April 21 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 19, 1875
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Religious	
11. BIRTHPLACE (State or foreign country) West Prussia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Dittmann		14. MOTHER'S MAIDEN NAME Anna Mann	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Sister M. Peter Fourrier		Address Notch Cliff, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. 1954 to April 1960 , that I last saw the deceased alive on April 12th 1960 , and that death occurred at 12.25 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i>		ADDRESS (Street, city or town, state) 7501 York Road Towson 4, Md.	
PHYSICIAN'S NAME (Type) Charles F. O'Donnell M.D.		DATE SIGNED 4/21/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4/23/60	22c. NAME OF CEMETERY OR CREMATORY Village Maria Cemetery	22d. LOCATION (City, town, or county) (State) Notch Cliff, Md. Towson, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Zoller		ADDRESS 6224 Eastern Ave. Ma	
24a. REC'D BY REGISTRAR APR 25 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1234

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

<p>NAME OF DECEASED JAMES H. SMITH</p>		<p>DATE OF BIRTH JAN 15 1890</p>	
<p>RESIDENCE 1234 E. MAIN ST. BALTIMORE, MD.</p>		<p>DATE OF DEATH JUN 10 1945</p>	
<p>CAUSE OF DEATH HEART DISEASE</p>		<p>PLACE OF DEATH HOME</p>	
<p>DATE OF INTERMENT JUN 12 1945</p>		<p>PLACE OF INTERMENT GREENWOOD CEMETERY</p>	
<p>SIGNATURE OF PHYSICIAN DR. J. H. SMITH</p>		<p>SIGNATURE OF REGISTRAR J. H. SMITH</p>	
<p>DATE OF SIGNATURE JUN 10 1945</p>		<p>DATE OF SIGNATURE JUN 10 1945</p>	

4262 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ma. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 52	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5421 Whitlock Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John William Dodd		4. DATE OF DEATH Month Day Year April 23/60 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 10, 1880
9. AGE (In years last birthday) 80		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Va.	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Dodd		14. MOTHER'S MAIDEN NAME Lucy---	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 215 03 8742	
17. INFORMANT Mrs. Bessie Dodd		Address 5421 Whitlock Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 10 days years.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 14 , 19 60 , to April 23 , 19 60 , that I last saw the deceased alive on April 22 , 19 60 , and that death occurred at 1:35 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5501 Dorset Park Ave Balt 7, Md. DATE SIGNED 4/25/60			
ACTUAL SIGNATURE Kennard Yaffe		PHYSICIAN'S NAME (Type) KENNARD YAFFE	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/26/60	
22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel		22d. LOCATION (City, town, or county) (State) Pasadena, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D.		24a. REC'D BY REGISTRAR DATE APR 26 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01130

CERTIFICATE OF DEATH

1932

Bellevue

MA.

White

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

John William Wood

MA.

Feb. 10, 1880

White

Male

Retired Carpenter

MA.

Bellevue

Bellevue

SIB OF BEAS Mrs. Beasie Wood, Belv Whitlock MA

Bellevue

W. J. Gentry

4/26/60

Bellevue

Bellevue P. O. Box 10000

Bellevue, MA.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4263

CERTIFICATE OF DEATH

64191

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home		d. STREET ADDRESS 3720 Fait Ave. # 24.	
3. NAME OF DECEASED (Type or print) GEORGE M. DOTTERWEICH.		4. DATE OF DEATH April 24, 1960.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 10, 1888
9. AGE (In years last birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Dotterweich		14. MOTHER'S MAIDEN NAME Mary K. Gephardt.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Wilhelmina E. Dotterweich		Address Same.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Hemorrhage DUE TO Arteriosclerotic Vascular Dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ----- DUE TO (c) -----		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. 6:00 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) Home		20f. (City or town) Baltimore (County) Baltimore (State) Md.	
21. I certify that I attended the deceased from Jan 1959 to Apr. 1960 , that I last saw the deceased alive on Apr. 5, 1960 , and that death occurred at 6:00 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank T. Kasik, Jr.		ADDRESS (Street, city or town, state) 9005 Harford Rd. Baltimore, Md.	
PHYSICIAN'S NAME (Type) FRANK T. KASIK		DATE SIGNED 4/25/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/27/60	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		22d. LOCATION (City, town, or county) 4430 Belair Rd. Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Zeiler		ADDRESS 6224 Eastern Ave. Baltimore, Md.	
24a. REC'D BY REGISTRAR APR 27 1960		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4264 CERTIFICATE OF DEATH

64192
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 36yr8mth28dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ora Middle Duncan Last Duncan		4. DATE OF DEATH Month April Day 5 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 16, 1878
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 81 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Gangley		14. MOTHER'S MAIDEN NAME Mary Foxwell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown	
INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardioacular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Possible carcinoma of the bladder			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 5 , 19 60 , to April 5 , 19 60 , that I last saw the deceased alive on April 5 , 19 60 , and that death occurred at 4:00p PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 4-5-60	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) 4/12/60		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Union of Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Anthony Board		ADDRESS 295 Greene St.	
24a. REC'D BY REGISTRAR DATE APR 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

1198

CERTIFICATE OF DEATH

4200

420.0

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Item 18 by none "Dr. R. Fisher 5-6-60 sma" 18-21 Film 262 5-9-MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 4223 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 64193											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halhthorpe c. LENGTH OF STAY IN 1b Carling's Brewery d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 5106 Maple Park Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) SIDNEY V. DUNCAN						4. DATE OF DEATH April 11, 19 60					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 14, 1899		9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Iron Worker				10b. KIND OF BUSINESS OR INDUSTRY Lehigh Construction				11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Duncan						14. MOTHER'S MAIDEN NAME Sarah Barrott					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 209-09-6264		17. INFORMANT Yvette M. Duncan Address 5106 Maple Park Ave.,					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Arteriosclerotic cardio vascular disease DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) ACTUAL SIGNATURE Russell S. Fisher, M.D. EXAMINER'S NAME (Type) DATE SIGNED 4/11/60											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-14-1960		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park		22d. LOCATION (City, town, or country) (State) Woodlawn, Md.					
23. FUNERAL DIRECTOR G. Howard Strong ADDRESS 3207 W. North Ave.,						24a. REC'D BY REGISTRAR APR 14 60 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks			

04119

4223

NO. 1000
1000

Colt's

Colt's

Colt's

Colt's

also

Iron Worker

Frank Duncan

Construction

Garth Barrett

502-03-8884 Ivette M. Duncan 6100 Maple Park Ave.

400

Serial 4-14-1980

C. Howard Snow 3807 North Ave.

Woodlawn

APR 1 1980

4265 CERTIFICATE OF DEATH

64194
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>3V01.4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in the Pines</u>		d. STREET ADDRESS <u>1763 E. North Avenue</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs. Aimee J. Earlbeck</u>		4. DATE OF DEATH Month Day Year <u>April 2nd 19 60</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 7, 1879</u>
9. AGE (In years last birthday) <u>80</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>1 mo</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Allen Collison</u>		14. MOTHER'S MAIDEN NAME <u>Jeannette</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Mrs. Elsie Herr 1763 E. North Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Decomposition</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Chronic Hypertensive Cardio-Vascular Disease</u> DUE TO (c) <u>15 yr.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2-14-</u> , 19 <u>59</u> , to <u>4-2-</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4-1-</u> , 19 <u>60</u> , and that death occurred at <u>6:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u>		ADDRESS (Street, city or town, state) <u>6209 Frederick Road Baltimore-28, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>		DATE <u>4-2-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/6/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24a. REC'D BY REGISTRAR <u>APR 5 '60</u>	
ADDRESS <u>5305 Harford Road #14</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1934

CERTIFICATE OF DEATH

Name of deceased		Date of birth	
John Doe		Jan 1, 1900	
Sex		Age at death	
Male		34	
Cause of death		Place of death	
Heart disease		Home	
Date of death		Time of death	
Jan 15, 1934		10:30 AM	
Signature of physician		Signature of registrar	
[Signature]		[Signature]	
Name of physician		Name of registrar	
Dr. J. A. Smith		John Doe	
Address of physician		Address of registrar	
123 Main St, City		456 Main St, City	
State of residence		County of residence	
Illinois		Cook	
Municipality of residence		City of residence	
Chicago		Chicago	
Occupation of deceased		Education of deceased	
Teacher		High School	
Marital status		Previous marriages	
Married		None	
Name of spouse		Date of marriage	
Jane Doe		Jan 1, 1910	
Name of informant		Relationship to deceased	
John Doe		Son	
Address of informant		City of informant	
123 Main St, City		Chicago	
State of informant		County of informant	
Illinois		Cook	
Municipality of informant		City of informant	
Chicago		Chicago	
Signature of informant		Signature of registrar	
[Signature]		[Signature]	
Name of informant		Name of registrar	
John Doe		John Doe	
Address of informant		Address of registrar	
123 Main St, City		456 Main St, City	
State of informant		County of informant	
Illinois		Cook	
Municipality of informant		City of informant	
Chicago		Chicago	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

4266

Item 2

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

film G260 4/11/60 44195

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. LENGTH OF STAY IN 1b 1 YEAR-3 MO.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) IDLE WILD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 2425 W. No. Ave. Balti. 16, Md.	
3. NAME OF DECEASED (Type or print) BLANCHE First Middle E Last ESCAVILLE		4. DATE OF DEATH Month APRIL Day 5 Year 1960	
5. SEX FE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-14-1868
9. AGE (In years lost birthday) 92 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U-S.	
13. FATHER'S NAME WILLIAM P. WRIGHT		14. MOTHER'S MAIDEN NAME SARAH TILSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-07-4115A	
17. INFORMANT Frank L. Smith Jr. - Cockeysville, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Cardiac 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Vascular Disease DUE TO (c) 5 years		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-6 19 59 , to 4-4 19 60 , that (I) (we) last saw the deceased alive on 4-4 19 60 , and that death occurred at 1528 M, from the causes and on the date stated above.			
22a. SIGNATURE Walter T. Kees		22b. DATE SIGNED 4/5/60.	
22c. PHYSICIAN'S NAME (Type) WALTER T. KEES		22d. ADDRESS COCKEYSVILLE, MD	
23a. BURIAL, CREMATION, RESUMPTION (Specify) BURIAL		23b. DATE THEREOF 4-8-60	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City, town, or county) (State) Pikesville	
24. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		25a. REC'D BY REGISTRAR APR 7 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

1 *
FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4267 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64196

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN lb Towson d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7600 Hillsway			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson d. STREET ADDRESS 7600 Hillsway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First EDWIN Middle GORDON Last ESTEP			4. DATE OF DEATH Month April Day 26 Year 19 60		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 10, 1908	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor For American Oil Co		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Morton Estep		14. MOTHER'S MAIDEN NAME Lydia Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 212-01-7279		17. INFORMANT Mrs. Evelyn Estep, 7600 Hillsway Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Thrombosis DUE TO Arteriosclerotic Heart Disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Petty		M.D. Charles S. Petty, M.D.		DATE SIGNED 4/26/60	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country) (State)		
Burial	4/29/60	Baltimore Cemetery	Baltimore, Maryland		
23. FUNERAL DIRECTOR Leonard J. Ruck 5305 Harford Road #14		ADDRESS		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE Arthur L. Huns
				DATE APR 27 '60	

MEDICAL CERTIFICATION

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM
SM 7/59

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4268 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64197

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sparrows Point		c. LENGTH OF STAY IN b MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bethlehem Steel Co. Dispensary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sparrows Point d. STREET ADDRESS 501 "E" Street	
3. NAME OF DECEASED (Type or print) Milton McKinley		4. DATE OF DEATH 4 29 1960		5. AGE (In years last birthday) 59	
6. SEX Male		7. COLOR OR RACE Wh.		8. DATE OF BIRTH Sept. 5, 1900	
9. MARIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler Foreman		10b. KIND OF BUSINESS OR INDUSTRY Steel	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Andrew J. Estes	
14. MOTHER'S MAIDEN NAME Lucy J. Walton		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 213-09-1587	
17. INFORMANT Mrs. Addie B. Estes - same as #4		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning 973.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). None		INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Ran hose from exhaust into car		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 5th Street parking lot - Sparrows Point-19, Md.		20c. TIME OF INJURY Month, Day, Year 4-29-60	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 5th Street parking lot - Sparrows Point-19, Md.		20f. (City or town) (County) (State) Baltimore County Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 4-29-60	
ACTUAL SIGNATURE Melvin B. Davis, M.D.		EXAMINER'S NAME (Type) Melvin B. Davis, M.D.		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-2-60		22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial	
22d. LOCATION (City, town, or country) (State) Baltimore County Md.		23. FUNERAL DIRECTOR Walter Brooks Bradley, Inc., -Dundalk 22		24a. REC'D BY REGISTRAR DATE MAY 3 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline		24c. REGISTRAR'S NAME Arthur S. Kline		24d. REGISTRAR'S ADDRESS Arthur S. Kline	



THE STATE
DEPARTMENT

4208

MINNESOTA EXHIBITS CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64198

Reg. Dist. No.

4232

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown c. LENGTH OF STAY IN 1b Reisterstown d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Knox Ave.			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville, Md. d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Albert Middle Lewis Last Fishpaw			4. DATE OF DEATH Month April Day 24 Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1942	9. AGE (In years last birthday) 17 yrs.	IF UNDER 1 YEAR Months 17 Days 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Contracting Firm		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Gilbert O. Fishpaw Sr.			14. MOTHER'S MAIDEN NAME Thelma L. Hudson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mrs. Gilbert O. Fishpaw, Cockeysville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to pressure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) On Rt. jaw & Larynx - Fractured mandible DUE TO (c) Auto accident					INTERVAL BETWEEN ONSET AND DEATH 1 hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Car upset on curve in Rd.					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car upset on curve in Rd.			
20c. TIME OF INJURY Month, Day, Year 6:30 P. M. April 24 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road	
20f. (City or town) Reisterstown		20g. (County) Baltimore		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE D. D. Caples		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4-24-60	
EXAMINER'S NAME (Type) D. D. CAPLES		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 27, 1960		22c. NAME OF CEMETERY OR CREMATORY Poplar Grove Cemetery	
22d. LOCATION (City, town, or county) Cockeysville, Maryland		22e. REC'D BY REGISTRAR APR 28 '60		22f. REGISTRAR'S SIGNATURE Arthur S. Hume	
23. FUNERAL DIRECTOR'S SIGNATURE John S. S. S.		ADDRESS Cockeysville, Md.		24. REGISTRAR'S SIGNATURE Arthur S. Hume	

MEDICAL CERTIFICATION

TO DEPARTMENT OF HEALTH: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltio. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltio.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltio.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltio. 3501 Berywn Avenue 3v01.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stella Maris Hospice		d. STREET ADDRESS Towson 4, Maryland	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle E. Last Folan		4. DATE OF DEATH Month April Day 5 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27, 1881
9. AGE (In years last birthday) 78 1/88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Worcester, Mass		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Morgan Folan		14. MOTHER'S MAIDEN NAME Barbara Costello	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 219-28-1642	
17. INFORMANT Sister Mary Kristine, Stella Maris Hospice		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO fulmonary Edema Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) HyperTensive Cardio Renal DUE TO Vascular Disease (c) 10 yrs		INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-12 , 19 56 , to 4-5 , 19 60 , that I last saw the deceased alive on April 4, 19 60 , and that death occurred at 3:45 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7501 York Rd. DATE SIGNED 4/5/60			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		PHYSICIAN'S NAME (Type) Charles F. O'Donnell M.D.	
22a. BURIAL, CREMATION, or other disposal (Specify) BURIAL		22b. DATE THEREOF 4-7-60	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. C. Ok-Towson, Inc., 1050 York Road, Towson		24a. REC'D BY REGISTRAR DATE APR 7 '60	
24b. REGISTRAR'S SIGNATURE Arthur E. H...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban poppers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6285

<p>1. Name of deceased: <u>JOHN J. BROWN</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of birth: <u>1880</u></p>	
<p>5. Place of birth: <u>NEW YORK</u></p>		<p>6. Date of death: <u>1925</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Place of death: <u>Home</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>1925</u></p>		<p>12. Office of registration: <u>NEW YORK</u></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

Item 23 Film G261 4/25/60 **CERTIFICATE OF DEATH**

64201

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 9 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle E. Last FOOTE		4. DATE OF DEATH Month APRIL Day 16 Year 19 60	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/1/22
9. AGE (In years last birthday) 38 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Plumbing	
11. BIRTHPLACE (State or foreign country) Parole, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Foote		14. MOTHER'S MAIDEN NAME Liza Denton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 214-05-2187	
17. INFORMANT Clin. Rec. VAH, Balto. Md. Ft. Howard Division		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CHRONIC PYELONEPHRITIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSION		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 7 19 60 , to April 16 19 60 , that (we) last saw the deceased alive on April 16 19 60 , and that death occurred at 4:15 P.M. the causes and an the date stated above.			
22a. SIGNATURE Ernest O. Brown, M.D.		22b. DATE SIGNED 4/16/60	
22c. PHYSICIAN'S NAME (Type) ERNEST O. BROWN, M.D.		22d. ADDRESS VAH, BALTO. MD. FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 20, 1960	
23c. NAME OF CEMETERY OR CREMATORY Chews Memorial Cemetery		23d. LOCATION (City, town, or county) (State) Owensville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Bernard Hardesty		25a. REC'D BY REGISTRAR DATE APR 19 '60	
ADDRESS Bernard Hardesty Funeral Home, Galesville, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

484x

1. **MARYLAND STATE DEPARTMENT OF HEALTH**
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
4271 **CERTIFICATE OF DEATH** **64202**

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN lb 56 Days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3001.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS Altamont Hotel Eutaw and Lanvale Streets	
3. NAME OF DECEASED (Type or print) First FERREL Middle B. Last FOSTER		4. DATE OF DEATH Month April Day 21 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH September 6, 1902 9. AGE (In years lost birthday) 57 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY City Jail	
11. BIRTHPLACE (State or foreign country) Joplin, Missouri		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Neil Foster		14. MOTHER'S MAIDEN NAME Melissa Worrell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO. 309-07-3772	
17. INFORMANT Clin. Records, VAH, Balto. 18, Md. Ft. Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTESTINAL OBSTRUCTION DUE TO ADENOCARCINOMA, CECUM (b) METASTATIC ADENOCARCINOMA, LIVER, PARAAORTIC AND REGIONAL LYMPH NODES (c) Pulmonary congestion and edema. Arteriosclerosis, generalized. Aortic aneurysm, abdominal, old.		INTERVAL BETWEEN ONSET AND DEATH RECENT OLD OLD	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from Feb. 25, 1960 , to April 21, 1960 , that (1) (we) last saw the deceased alive on April 21, 1960 , and that death occurred at 5:10 PM on the causes and on the date stated above.			
22a. SIGNATURE John D. Talbert, M.D.		22b. DATE 4/22/60	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D.		22d. ADDRESS VAH, BALTIMORE 18, Md., FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-25-60	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Chok-Blight, Inc.		25a. REC'D BY REGISTRAR APR 27 1960	
ADDRESS 6009 Harford Road, Balto. 14, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

02503

CENTRAL BANK OF CANADA

1831



TO THE HONORABLE THE SECRETARY OF THE
TREASURY
OTTAWA
FROM THE
MANAGER OF THE
CENTRAL BANK OF CANADA
SIR,
I have the honor to acknowledge the receipt of your letter of the 14th inst. in relation to the above subject.
In reply to inform you that the same has been forwarded to the proper authorities for their consideration.
Very respectfully,
J. H. [Signature]
Manager of the Central Bank of Canada

1933

CERTIFICATE OF DEATH

1933



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4273

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kingsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kingsville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <i>Belair Road Box 685</i>		d. STREET ADDRESS <i>Belair Road Box 685</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Dixie Gertrude Francis</i>		4. DATE OF DEATH Month Day Year <i>April 13 1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 15-1891</i>
9. AGE (In years last birthday) <i>68</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <i>School Cafeteria</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Pyramia</i>	
11. BIRTHPLACE (State or foreign country) <i>Pyramia</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Edward E. M. Taylor</i>		14. MOTHER'S MAIDEN NAME <i>Emme Laurie Stomback</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-30-6070</i>	
17. INFORMANT <i>H.C. Francis</i>		Address <i>Kingsville Maryland</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Nephrosis</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <i>ASCVD</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June</i> , 1957, to <i>April</i> , 1960, that I last saw the deceased alive on <i>April 4</i> , 1960, and that death occurred at <i>4:00</i> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>William C. Tyson</i> M.D.		ADDRESS (Street, city or town, state) <i>Kingsville, Md.</i> DATE SIGNED <i>4-14-60</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>April 16-1960</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Belair Memorial Gardens</i>		22d. LOCATION (City, town, or county) (State) <i>Belair Harbor Co. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Surgee Funeral Home</i> ADDRESS <i>3631 Falls Road</i>		24a. REC'D BY REGISTRAR DATE <i>APR 18 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur E. Hume</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

64205
Reg. Dist. No.

4224

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Halethorpe	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1717 Park Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Julia E. Middle Gartrell Last		4. DATE OF DEATH Month 4/15/60 Day Year 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/29/1882
9. AGE (In years lost birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alois Schaar		14. MOTHER'S MAIDEN NAME Katherine Rimbach	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. Charles L. Gartrell	
17. INFORMANT Address Charles L. Gartrell 1717 Park Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 4433X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c) 2 Yrs		INTERVAL BETWEEN ONSET AND DEATH 1 wk	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 8, 1960 to April 15, 1960 , that I last saw the deceased alive on April 15, 1960 , and that death occurred at 11:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE A. Bradley Laugharty		ADDRESS (Street, city or town, state) DATE SIGNED 4-15-60	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/18/60	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	22d. LOCATION (City, town, or county) (State) Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Ave.	
24a. REC'D BY REGISTRAR APR 19 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Journal of Management Inquiry 18(6)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4274

CERTIFICATE OF DEATH

64206
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12		c. LENGTH OF STAY IN TB 3101.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mercy Villa Bellona Avenue		d. STREET ADDRESS Homewood Apartments	
3. NAME OF DECEASED (Type or print) First Carlotta Middle B Last Geoghegan		4. DATE OF DEATH Month April Day 22 Year 1960	
5. SEX FEMAL	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1880
9. AGE (In years last birthday) 79		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Brady		14. MOTHER'S MAIDEN NAME Sarah Ann Printy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-09-5671	
INFORMANT Wm. C. Geoghegan, Cambria Farms Rd., Phoenix, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma sigmoid colon. 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 48 to April 22 , 19 60 , that I last saw the deceased alive on April 22 , 19 60 , and that death occurred at 1901 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Stephen J Van Hill		ADDRESS (Street, city or town, state) 3001 Greenway Drive	
PHYSICIAN'S NAME (Type) Stephen J Van Hill M.D.		DATE SIGNED 4-22-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-25-60	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		22d. LOCATION (City, town, or county) (State) Woodlawn, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc., 1050 York Road, Towson		24a. REC'D BY REGISTRAR APR 25 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

DEATH CERTIFICATE

1934

MADE IN THE STATE OF NEW YORK

NAME OF DECEASED
DATE OF DEATH

PLACE OF DEATH
CITY AND STATE

CAUSE OF DEATH
MANNER OF DEATH

AGE
SEX

DATE OF BIRTH
PLACE OF BIRTH

EDUCATION
OCCUPATION

RELIGION
MARRIAGE

PREVIOUS ILLNESS
PREVIOUS SURGERY

PREVIOUS TRAUMA
PREVIOUS DRUGS

PREVIOUS ACCIDENTS
PREVIOUS DEATHS

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CITY AND STATE

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ACCIDENTS

PREVIOUS DEATHS

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ACCIDENTS

PREVIOUS DEATHS

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CITY AND STATE

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ACCIDENTS

PREVIOUS DEATHS

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ACCIDENTS

PREVIOUS DEATHS

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CITY AND STATE

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ACCIDENTS

PREVIOUS DEATHS

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ACCIDENTS

PREVIOUS DEATHS

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CITY AND STATE

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ACCIDENTS

PREVIOUS DEATHS

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ACCIDENTS

PREVIOUS DEATHS

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Item 18 Film 263 5-24-60											
MAYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
4216 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 64207											
1. PLACE OF DEATH e. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 18			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bear Creek Bridge				d. STREET ADDRESS 301 E. 29th Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JERRY G GILL				4. DATE OF DEATH Month April Day 29 Year 1960							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 26, 1936		9. AGE (In years last birthday) 24 yrs.		IF UNDER 1 YEAR Months 24 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY Painting				11. BIRTHPLACE (State or foreign country) Milford, Conn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nathaniel Gill (deceased)				14. MOTHER'S MAIDEN NAME Doris McKean							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO. W.W.II				17. INFORMANT Doris Gill, 142 State St., Brockport, N.Y.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Crushing injury of right chest and blunt-force injury of head, with depressed skull fracture											
DUE TO (b) Asphyxia due to drowning											
DUE TO (c) Crushing injury of right chest and blunt-force injury of head, with depressed skull fracture.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Apparently knocked off painter's scaffold by moving bridge span							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 4/29/60				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bridge			
				20f. (City or town) Baltimore				(County) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE W. Bradley King, Jr.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 4/29/60			
EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>							
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL				22b. DATE THEREOF 5-2-60		22c. NAME OF CEMETERY OR CREMATORY Lakeview Cemetery		22d. LOCATION (City, town, or country) (State) Sweedon, New York			
23. FUNERAL DIRECTOR Wm. Cook, Inc., 1217 St. Paul Street						ADDRESS		24a. REC'D BY REGISTRAR MAY 3 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

THE STATE
DEPARTMENT

4510

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1945

Belmont

Belmont

Belmont

Belmont

Belmont

Belmont

Belmont

Belmont

Belmont

Belmont

Belmont

Belmont

Belmont

4510

Practitioner of medicine and surgery
injury of head, with associated skull fracture

Examination conducted on patient's body and by having injuries

4510

Belmont

Belmont

Belmont

Belmont

Practitioner of medicine and surgery

4510

Belmont

Belmont

Belmont

Belmont

Belmont

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4275 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **64208**

1. PLACE OF DEATH a. COUNTY Balti. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE md. b. COUNTY Balti.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville, Md. 4 yrs.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Pikesville 8			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7500 Richridge Rd.				d. STREET ADDRESS 1 7500 Richridge Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNA Middle SEIDMAN Last GOLDSTEIN				4. DATE OF DEATH Month Apr Day 6 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 22, 1900	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Issac Seidman				14. MOTHER'S MAIDEN NAME Mary. ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None.		17. INFORMANT Oscar Goldstein		Address 7500 Richridge Rd. Pikesville 8.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 12 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None.					
20c. TIME OF INJURY Hour a. m. None p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE D. D. Caples				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) D. D. CAPLES				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-8-60		22c. NAME OF CEMETERY OR CREMATORY Arlington		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Kewin				ADDRESS 2100 Eutaw Place		24a. REC'D BY REGISTRAR DATE APR 7 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Haines			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

44208

NAME OF DECEASED [Blank]		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
AGE [Blank]		OCCUPATION [Blank]	
DATE OF DEATH [Blank]		PLACE OF DEATH [Blank]	
TIME OF DEATH [Blank]		CAUSE OF DEATH [Blank]	
MANNER OF DEATH <input type="checkbox"/> NATURAL <input type="checkbox"/> ACCIDENTAL <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE		MEDICAL HISTORY [Blank]	
PRESENT ILLNESS [Blank]		POST-MORTEM EXAMINATION [Blank]	
SIGNATURE OF EXAMINER [Blank]		SIGNATURE OF WITNESSES [Blank]	
OFFICIAL SEAL [Blank]		OFFICIAL SEAL [Blank]	

RECEIVED
17/11/2017

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4276

Item 13 Film G261 4/25/60 cap

CERTIFICATE OF DEATH

64209
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2733 Glendale Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mr. Vinson</u> Middle <u>James</u> Last <u>Gordon</u>		4. DATE OF DEATH Month <u>April</u> Day <u>15th</u> Year <u>19 60</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31, 1905</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months <u>54</u> Days <u>54</u> Hours <u>54</u> Min. <u>54</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief of Records</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>S. S. Office</u>	
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Jennings Gordon</u>		14. MOTHER'S MAIDEN NAME <u>Martha Cruikshank</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>206-20-9427</u>	
17. INFORMANT <u>Mrs. Geneva Gordon</u>		Address <u>2733 Glendale Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>162.1 Branchogenic Carcinoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>14 MO.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>2/21/59</u> , 19____, to <u>4/15/60</u> , 19____, that I lost the deceased alive on <u>4/14/60</u> , 19____, and that death occurred at <u>10:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harold A. Grott</u>		ADDRESS (Street, city or town, state) <u>8100 Harford Rd</u> DATE SIGNED <u>4/16/60</u>	
PHYSICIAN'S NAME (Type) <u>HAROLD A. GROTT, M.D.</u>		<u>BALTO-14, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/19/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	22d. LOCATION (City, town, or county) <u>Baltimore Maryland</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>	
24a. REC'D BY REGISTRAR <u>APR 19 60</u>		24b. REGISTRAR'S SIGNATURE <u>William J. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1915

CERTIFICATE OF DEATH

1915

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Time of Death		Occupation		Residence	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Date of Burial		Place of Burial		Cause of Burial	
Time of Burial		Occupation		Residence	
Signature of Minister		Signature of Registrar		Signature of Coroner	
Date of Interment		Place of Interment		Cause of Interment	
Time of Interment		Occupation		Residence	
Signature of Minister		Signature of Registrar		Signature of Coroner	
Date of Cremation		Place of Cremation		Cause of Cremation	
Time of Cremation		Occupation		Residence	
Signature of Minister		Signature of Registrar		Signature of Coroner	
Date of Disposition		Place of Disposition		Cause of Disposition	
Time of Disposition		Occupation		Residence	
Signature of Minister		Signature of Registrar		Signature of Coroner	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4277

Items 8, 9 Film 6260 4-8-60 et

CERTIFICATE OF DEATH

64210

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4503 Kenwood Ave.		d. STREET ADDRESS 4503 Kenwood Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Robert Fulton Groshans		4. DATE OF DEATH Month Day Year April 2 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 24 1897 / 1898
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clothing cutter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Groshans		14. MOTHER'S MAIDEN NAME Sophis Fauler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. INFORMANT Mrs Helen Groshans 4503 Kenwood Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary occlusion 420.1 DUE TO Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Insufficiency DUE TO old Posterior Myocardial Infarction (c) Heart block - arrhythmia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Heart block - arrhythmia		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 16 19 60 to April 2 19 60 , that I last saw the deceased alive on April 2 19 60 , and that death occurred at 345 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE William A. Anderson M.D.		ADDRESS (Street, city or town, state) 3001 Shavon Drive Baltimore Md.	
DATE SIGNED APR 5 '60		DATE SIGNED Arthur S. Kraus	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF April 5/60	
22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road		24a. REC'D BY REGISTRAR DATE APR 5 '60	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
4278
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04211

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		c. LENGTH OF STAY IN 1b 10 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 17818 RIVERDALE AVE.		d. STREET ADDRESS 17818 RIVERDALE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) C. CHARLOTTE C. GROVES		4. DATE OF DEATH APRIL 7 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 12, 1897
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME FRANK WISNIEWSKI		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 7818 Riverdale Ave.	
17. INFORMANT Wm. J. Groves		Address 7818 Riverdale Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) multiple sclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1958 to April 7, 1960 , that (I) (we) last saw the deceased alive on April 7, 1960 , and that death occurred at 12 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Emmett P. Davis		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) EMMETT P. DAVIS		22d. ADDRESS 5317 BELAIR Rd BALTO MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/11/60	
23c. NAME OF CEMETERY OR CREMATORY ONK LAWN. CEM.		23d. LOCATION (City, town, or county) (State) BALTO, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Hartley Miller		25a. REC'D BY REGISTRAR APR 8 '60	
ADDRESS 2334 Jefferson St.		25b. REGISTRAR'S SIGNATURE Curtis P. Thomas	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4279

CERTIFICATE OF DEATH

04212
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5/Lansdowne 27	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor Nursing Home		d. STREET ADDRESS 12 Third Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Gunther Last Gunther		4. DATE OF DEATH Month April Day 14 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 9, 1879
9. AGE (In years last birthday) 80		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (ret'd) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Garment Factory	
11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME (unknown) Gunther		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
INFORMANT Mr. Francis P. Saunders, 1707 Spring St		Address Spring Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 1, 1960 to April 14, 1960 , that I last saw the deceased alive on April 12, 1960 , and that death occurred at 5 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Morris W. Steinberg M.D.		ADDRESS (Street, city or town, state) 3913 Hollins Ferry Road DATE SIGNED 4/14/60	
PHYSICIAN'S NAME (Type) Morris W. Steinberg		3913 Hollins Ferry Road	
22a. BURIAL, CREMATION, or other disposition (Specify) BURIAL		22b. DATE THEREOF 4-16-60	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		22d. LOCATION (City, town, or county) (State) 4430 Belair Road	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		ADDRESS 1217 St. Paul Street	
24a. REC'D BY REGISTRAR APR 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

422

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64213

Reg. Dist. No.

4280

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLE RIVER		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 49 FOXGLOVE LANE #20 MD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARGUERITE HAINES		4. DATE OF DEATH APRIL 22 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 3, 1902
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK		10b. KIND OF BUSINESS OR INDUSTRY COTTAGE INN	
11. BIRTHPLACE (State or foreign country) BALTIMORE MD.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME GEORGE TAYLOR		14. MOTHER'S MAIDEN NAME UNKNOWN GREEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 220-24-6516	
17. INFORMANT VALLADIE CLARK		Address 49 FOXGLOVE LANE #20	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive C-V Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M.B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M.B. DAVIS MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF APRIL 25, 1960	
22c. NAME OF CEMETERY OR CREMATORY Ebenezer Cem.		22d. LOCATION (City, town, or county) (State) CHASE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Jesseln Funeral Home 7401 Belair Rd. #6		24a. REC'D BY REGISTRAR DATE APR 27 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

4281 CERTIFICATE OF DEATH

64214
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND Baltimore				2. USUAL RESIDENCE (Where deceased lived. If institution: Reside before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 13X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home				d. STREET ADDRESS 434 Columbia Road			
3. NAME OF DECEASED (Type or print) First ELEANOR F. Middle HARDY Last Female 5. SEX White 6. COLOR OR RACE WIDOWED 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				4. DATE OF DEATH Month April Day 12 Year 1960			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Howard County, Md.	
13. FATHER'S NAME Randolph Day				14. MOTHER'S MAIDEN NAME Alberta Warfield			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) CVA (c) ASCVD				INTERVAL BETWEEN ONSET AND DEATH 3 Wks 10 Yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 3-5 , 19 58 to 4-12 , 19 60 , that I last saw the deceased alive on 4-12 , 19 60 , and that death occurred at 4 P M , from the causes and on the date stated above.							
ACTUAL SIGNATURE PV Thorpe				ADDRESS (Street, city or town, state) 409 Columbia Road			
PHYSICIAN'S NAME (Type) Peter Van B Thorpe M.D.				DATE SIGNED 15 Ellicott City, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-15-60		22c. NAME OF CEMETERY OR CREMATORY Damascus Methodist		22d. LOCATION (City, town, or county) (State) Damascus, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DATE APR 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

334

FOR STATE
HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4282 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04215

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>		c. LENGTH OF STAY IN 1b <u>4 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1701 Reisterstown Road</u>	
3. NAME OF DECEASED (Type or print) <u>John Wesley Hart</u>		4. DATE OF DEATH <u>April 12, 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 12, 1948</u>
9. AGE (In years last birthday) <u>12</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		11b. KIND OF BUSINESS OR INDUSTRY	
12. BIRTHPLACE (State or foreign country) <u>Mareta, South Carolina</u>		13. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14. FATHER'S NAME <u>Lyman Eugene Hart</u>		15. MOTHER'S MAIDEN NAME <u>Pearl Garland</u>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		17. SOCIAL SECURITY NO. <u>None</u>	
18. INFORMANT <u>Mr. Lyman E. Hart, 1701 Reisterstown Rd.</u>		19. ADDRESS <u>Pikesville 8, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound Fracture of skull (multiple)</u> 812X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Riding bicycle S. on Reist. Rd., fell off & was struck by auto.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>4:25</u> p. m. <u>Apr. 12 1960</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Reist. Rd.</u>	20f. (City or town) (County) (State) <u>Pikesville Balto. Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>D. D. Caples</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D. D. Caples, M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE TIME OF <u>April 15, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Church Of Christ Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>U.S. Pikesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Pikesville 8, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE APR 19 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1515

HAWAII STATE DEPARTMENT OF HEALTH-BALHORE 10
1925 MEDICAL EXAMINER'S CERTIFICATE OF DEATHHAWAII STATE
DEPARTMENT OF HEALTH

8452

1. Name of deceased: _____
2. Sex: _____
3. Age: _____
4. Date of birth: _____
5. Place of birth: _____
6. Occupation: _____
7. Cause of death: _____
8. Date of death: _____
9. Time of death: _____
10. Signature of medical examiner: _____
11. Signature of coroner: _____
12. Signature of registrar: _____
13. Signature of physician: _____
14. Signature of nurse: _____
15. Signature of other: _____

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4283 CERTIFICATE OF DEATH

64216

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN 1b <u>5 Days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>576 Oxford Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) (Served as <u>GEORGE</u> ^{First} <u>W.</u> ^{Middle} <u>HATCHER</u> ^{Last}) 5. SEX <u>Male</u> 6. COLOR OR RACE <u>Colored</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>August 4, 1892</u> 9. AGE (In years lost birthday) <u>67</u> yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.				4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>1960</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Longshoreman</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Shipping</u> 11. BIRTHPLACE (State or foreign country) <u>Fayetteville, N. Carolina</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>John Hatcher</u> 14. MOTHER'S MAIDEN NAME <u>Sarah Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u> 16. SOCIAL SECURITY NO. <u>217-01-9910</u> 17. INFORMANT <u>Clin. Records, VAH, Balto. 18, Md. Ft. Howard Division</u> Address				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE HEART FAILURE</u> DUE TO (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that <u>11</u> (this hospital) attended the deceased from <u>April 24, 1960</u> to <u>April 29, 1960</u> , that <u>1</u> (we) last saw the deceased alive on <u>4/29/60</u> 19 <u>60</u> , and that death occurred at <u>4:45 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>John D. Talbert, M.D.</u> 22c. PHYSICIAN'S NAME (Type) <u>JOHN D. TALBERT, M.D.</u>				22b. DATE <u>4/29/60</u> 22d. ADDRESS <u>VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/3/1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Marshall P. Hayes</u> ADDRESS <u>638 N. Gilmor St.</u> <u>Marshall Hayes, 638 N. Gilmor St., Balto. Md.</u>				25a. MAYOR'S REGISTRAR DATE <u>MAY 2 1960</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. King</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF TEXAS
COUNTY OF DALLAS



Know all men by these presents, that _____ of the County of _____ State of _____ do hereby certify that _____ of the County of _____ State of _____ is the owner of the following described land, to-wit:

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4284

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64217

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Marsh				c. LENGTH OF STAY IN TB			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 145 Bird River Grove Rd.				d. STREET ADDRESS Box 145 Bird River Grove Rd.			
3. NAME OF DECEASED (Type or print) First Anna Middle H. Last Hausler				4. DATE OF DEATH Month April Day 27 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 22, 1895	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 27 Days 19 Hours 60 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown Turling		14. MOTHER'S MAIDEN NAME Unknown Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Roy Hausler Address 6100 Sefton Ave. 14			
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Arterio Sclerosis DUE TO (c) Myocardial infarction						INTERVAL BETWEEN ONSET AND DEATH 10 min. 2 1/2 hrs 5 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE JACK C COLLINS				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JACK C COLLINS				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-29-1960		22c. NAME OF CEMETERY OR CREMATORY Oaklawn		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lorraine Funeral Home				ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR APR 29 60	
				24b. REGISTRAR'S SIGNATURE Charles S. Miller			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 c, Film G261 4/26/60 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

64220

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Distinct before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville 8, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Own home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <u>100 Old Court Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Catherine Williams Hein</u>				4. DATE OF DEATH Month Day Year <u>April 13, 1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 18, 1868</u>	9. AGE (In years last birthday) <u>91</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John Williams</u>				14. MOTHER'S MAIDEN NAME <u>Anna Plock</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>none</u>		INFORMANT <u>Pikesville 8, Md.</u> <u>Mr. Paul Hein, 211 Claredon Ave.,</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> DUE TO <u>491 X</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SMOKING</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>APRIL 11, 1960</u> , to <u>APRIL 13, 1960</u> , that I last saw the deceased alive on <u>APRIL 12, 1960</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Francis T Daly</u>				ADDRESS (Street, city or town, state) <u>1725 ROSTERTOWN Rd Pikesville 8, Md.</u>			
PHYSICIAN'S NAME (Type) <u>FRANCIS T DALY</u>				DATE SIGNED <u>4/15/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 16, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>London Park Burial</u>		22d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Pikesville</u>				24a. REC'D BY REGISTRAR <u>APR 19 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0-1830

CERTIFICATE OF D. R. H.

1830

1830



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4217 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

b4221
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dundalk</u> <i>Balto.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>			c. LENGTH OF STAY IN 1b <u>53</u> <u>Dundalk</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53</u> <u>Dundalk</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2620 Yorkway</u>				d. STREET ADDRESS <u>1</u> <u>2620 Yorkwat</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Miller Henderson VI</u>				4. DATE OF DEATH Month Day Year <u>April 22,</u> <u>19</u> <u>60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 19, 1911</u>	
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Steel</u>		11. BIRTHPLACE (State or foreign country) <u>Penna</u>	
13. FATHER'S NAME <u>Robert M. Henderson</u>				14. MOTHER'S MAIDEN NAME <u>Lilly Weaver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>				16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT Address <u>Mrs. Pauline Henderson 2620 Yorkway</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occ.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>(c)</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(b)</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Sack P Collins</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Sack P Collins</u>				DATE SIGNED <u>4-23-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 26, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Carlyle, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home Dundalk, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any doubt is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

4286

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chase</u>		c. LENGTH OF STAY IN 1b <u>X Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ebenezer Rd.</u>		d. STREET ADDRESS <u>Ebenezer Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>August</u> First <u>Hennlein</u> Middle <u></u> Last <u></u>		4. DATE OF DEATH <u>April</u> Month <u>19</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 22, 1865</u>
9. AGE (In years last birthday) <u>94</u> yrs.		IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ADAM HENNLEIN</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET LUDWIG</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>George W. Hennlein</u>		Address <u>Chase, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gangrene - Peripheral Vascular Disease</u> DUE TO <u>422-1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A S C V D</u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 1958</u> to <u>April 1, 1960</u> , that I last saw the deceased alive on <u>April 14, 1960</u> , and that death occurred at <u>11:45</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William A. Tyson</u>		DATE SIGNED <u>4-19-60</u>	
PHYSICIAN'S NAME (Type) <u>William A. Tyson</u>		ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-22-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Chase, Balto. Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	
24a. REC'D BY REGISTRAR <u>APR 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneiss</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3404

DIWOD TERNAM

AM

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1906 Adams Road		d. STREET ADDRESS 1906 Adams Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY First Hillebrand Middle A. Last HILLEBRAND		4. DATE OF DEATH Month April Day 6 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1921
9. AGE (In years last birthday) 39 yrs.		10. IF UNDER 1 YEAR Months 39 Days 39 Hours 39 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Janowitz		14. MOTHER'S MAIDEN NAME Mary Kwedar	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. INFORMANT Address Mrs. Mary Janowitz 6609 Pine Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis DUE TO 002X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 15 yrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1 , 19 45 , to Apr 6 , 19 60 that I last saw the deceased alive on April 1 , 19 60 , and that death occurred at 6 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED M. W. Jacobson M.D. 6821 Reisterstown Rd Baltimore, Md. 4-6-60 ACTUAL SIGNATURE M. W. JACOBSON M.D. 6821 Reisterstown Rd Baltimore, Md. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 8, 1960	
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary		22d. LOCATION (City, town, or county) (State) Dundalk, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home Dundalk, Md.		24a. REC'D BY REGISTRAR DATE APR 11 '60	
24b. REGISTRAR'S SIGNATURE C. L. H. H. H.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1913

Religion

Interment

Place of Birth

Age

Sex

Color

Married

Signature of Registrar

Signature of Physician



Signature of Coroner

Signature of Jury

Signature of Witnesses

Signature of Deceased

Signature of Family

Signature of Friends

Signature of Clergy

Signature of Burial Society

Signature of Undertaker

Signature of Cemetery

4287

CERTIFICATE OF DEATH

64224
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 30	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The House in The Pines 16 Fusting Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Georgia Middle N Last Holdson		4. DATE OF DEATH Month April Day 20 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1889
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireworks Factory		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Nobeltt		14. MOTHER'S MAIDEN NAME Anna Storke	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. 219-14-3250	
17. INFORMANT George R. Holdson, 2519 Smith Avenue, Zone 30		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO cerebral hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypertension (c) —		INTERVAL BETWEEN ONSET AND DEATH 5 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-26-58 to 4-20-60 , 19 60 , that I last saw the deceased alive on 4-20-60 , and that death occurred on 4-20-60 , from the causes and on the date stated above.		M, from the causes and on the date stated above.	
ACTUAL SIGNATURE Harry S. Gimbel		ADDRESS (Street, city or town, state) 4605 Edmondson Avenue	
PHYSICIAN'S NAME (Type) HARRY S. GIMBEL		DATE SIGNED 4-21-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-23-60	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE APR 25 '60	
24b. REGISTRAR'S SIGNATURE Arthur J. H.			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1954

STATE OF TEXAS

1954

ABSTRACT

1954

1954

1954

1954

1954

1954

1954

1954

1954

4288

CERTIFICATE OF DEATH

64225
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>				c. LENGTH OF STAY IN 1b <u>8 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1603 Gail Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JANNIE M. HOLLER</u>				4. DATE OF DEATH <u>APR. 3 1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 1 - 1888</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Safius Setzler</u>				14. MOTHER'S MAIDEN NAME <u>Nora Nelson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>				16. SOCIAL SECURITY NO. <u>Marvin A. Holler</u>			
17. INFORMANT Address <u>(Same)</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Pneumonitis</u> (c) <u>Multiple metastatic carcinomas</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>8 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 1960 to <u>April 2</u> , 1960, that I last saw the deceased alive on <u>April 2</u> , 1960, and that death occurred at <u>9:04 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John B. Little</u>				ADDRESS (Street, city or town, state) <u>1515 Martin Blvd, Balt 20102</u>			
PHYSICIAN'S NAME (Type) <u>MD</u>				DATE SIGNED <u>4-4-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>4-4-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREEN LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>Belmont N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connelly - Essex Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fink</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

1938

NAME

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4289 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64226

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Balto		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore--rural		c. LENGTH OF STAY IN 1b 1 1/2 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore--rural--Parkville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS 2905 Second Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Antonia Middle A Last Horecka			4. DATE OF DEATH Month April Day 8 Year 19 60		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 April 1889		9. AGE (In years last birthday) 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) New York	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Kratochill			14. MOTHER'S MAIDEN NAME Don't know		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Josephine Stronsky(daughter)same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic Cardio Vascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)					INTERVAL BETWEEN ONSET AND DEATH undet
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Petersburg Va	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John C. Hyle		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4-8-60	
EXAMINER'S NAME (Type) John C Hyle MD		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) removal	22b. DATE THEREOF April 9/60	22c. NAME OF CEMETERY OR CREMATORY Blanford Cemetery		22d. LOCATION (City, town, or county) (State) Petersburg Va	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road		ADDRESS		24a. REC'D BY REGISTRAR DATE APR 11 '60	24b. REGISTRAR'S SIGNATURE Charles L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

64227

4290

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE				c. LENGTH OF STAY IN 1b 6 MONTHS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME				d. STREET ADDRESS 13605 DUXLEY LANE			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First FLORA Middle HUBER Last				4. DATE OF DEATH Month APRIL Day 19 Year 1960.			
5. SEX FE		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-1-1866	
9. AGE (In years last birthday) 93 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNA.	
12. CITIZEN OF WHAT COUNTRY? U-S							
13. FATHER'S NAME GILMORE HULL				14. MOTHER'S MAIDEN NAME MARTHA MCCARRER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Frank L. Smith, Cockeysville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-Sclerotic Cardiac 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) Vascular Disease DUE TO (c) Myocardial Infarction							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial Infarction							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Columbia, Pennsylvania				(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10-14-1953 to 4-18-1960 , that (I) (we) last saw the deceased alive on 4-12-1960 , and that death occurred at 11:35 M. from the causes and on the date stated above.							
22a. SIGNATURE Walter T. Kees				22b. DATE SIGNED 4/9/60			
22c. PHYSICIAN'S NAME (Type) WALTER T. KEES				22d. ADDRESS Cockeysville, Md.			
23a. BURIAL, CREMATION, or other disposal (Specify) BURIAL		23b. DATE THEREOF 4-22-60		23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		23d. LOCATION (City, town, or county) (State) Columbia, Pennsylvania	
24. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				25a. REC'D BY REGISTRAR DATE APR 21 '60		25b. REGISTRAR'S SIGNATURE W. L. Smith	

CERTIFICATE OF DEATH

1920

MARYLAND

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4291 CERTIFICATE OF DEATH

64228

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN lb 18 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (29) d. STREET ADDRESS 5423 Channing Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First ROLAND Middle A. Last HYLAND			4. DATE OF DEATH Month April Day 4 Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1887	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months 72 Days 1 Hours 19 Min. 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman-Retired		10b. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME William A. Hyland			14. MOTHER'S MAIDEN NAME Mary Jane Hardy		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1		17. INFORMANT Clinical Records VAH, Balto. 18, Md. Ft. Howard Div.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL INFARCTION (c) ARTERIOSCLEROSIS WITH ENCEPHALOMALACIA					INTERVAL BETWEEN ONSET AND DEATH 10 DAYS UNKNOWN UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operation 2/18/60 University Hospital, Balto. Md. Trephine					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from March 17, 1960 , to April 4, 1960 , that (I) (we) last saw the deceased alive on 4-4-60 , and that death occurred at 10:35 PM , from the causes and on the date stated above.					
22a. SIGNATURE Caridad E. Gonzalez		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4/5/60	
22c. PHYSICIAN'S NAME (Type) CARIDAD E. GONZALEZ, M.D.		22d. ADDRESS VAH, BALTIMORE 18 MD, FT. HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-8-60	23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	23d. LOCATION (City, town, or county) Baltimore Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight		ADDRESS 6009 Harford Rd., Balto. 14, Md.		25a. REC'D BY REGISTRAR APR 11 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Howard

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(12) 6.012.452

CONSTITUTIONAL

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04229 32

1. PLACE OF DEATH COUNTY <u>Baltimore County</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Mt. Wilson, Maryland</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Baltimore City</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore 18</u> STREET ADDRESS (If rural give location) <u>2643 Maryland Ave</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>Vincent</u> (Middle) <u>Leo</u> (Last) <u>Ianneo</u>			4. DATE OF DEATH (Month) <u>4</u> (Day) <u>17</u> (Year) <u>1960</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>4/16/1889</u>	9. AGE last birthday <u>71</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>clothing</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>John Ianneo</u>				
14. MOTHER'S MAIDEN NAME <u>Rose Liberski</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>No</u>				
16. SOCIAL SECURITY NO. <u>231-09-8413</u>			17. INFORMANT & ADDRESS <u>Hosp. Records, Mt. Wilson State Hospital</u>				
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 200. IMMEDIATE CAUSE (A) <u>Lymphosarcoma</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) (C)					INTERVAL BETWEEN ONSET AND DEATH <u>6 month</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Moderately Advanced Pulmonary Tuberculosis</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
19a. DATE OF OPERATION <u>002X</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/17</u> , 19 <u>60</u> , to <u>4/17</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/17</u> , 19 <u>60</u> , and that death occurred at <u>1:10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William Newcomer</u>		ADDRESS (Street, city, town, state) <u>M.D. Superintendent, Mt. Wilson, Maryland</u>		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 20/60</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>			
24. REC'D BY REGISTRAR <u>APR 20 '60</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Weller</u>			
DATE		ADDRESS		322 S. High St.			

CERTIFICATE OF DEATH

1. NAME OF DECEASED: JOHN J. ROBERTS

2. SEX: MALE

3. AGE: 45

4. DATE OF BIRTH: 1912

5. PLACE OF BIRTH: NEW YORK

6. OCCUPATION: LABORER

7. CAUSE OF DEATH: HEART DISEASE

8. PLACE OF DEATH: HOME

9. DATE OF DEATH: 1958

10. SIGNATURE OF PHYSICIAN: [Signature]

11. SIGNATURE OF REGISTRAR: [Signature]

12. COUNTY: BALTIMORE

13. CITY: BALTIMORE

14. STREET: 1234 MAIN ST.

15. APARTMENT: 2

16. ZIP CODE: 21201

17. MARRIAGE: 1935

18. SPOUSE: MARY J. ROBERTS

19. CHILDREN: JOHN J. ROBERTS JR., MARY J. ROBERTS

20. OTHER: [Blank]

SHORTCUTS

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his or her last illness. It should be filled out as soon as possible after death, and should be filed with the local health department or the State Department of Health. It is a legal document and its contents are subject to review by the State Department of Health.

2. The cause of death should be stated in as much detail as possible, and should be based on the physician's own knowledge and the results of any autopsy or other examination. It should be stated in terms of the disease or condition which caused the death, and not in terms of the symptoms or signs which were observed.

3. The place of death should be stated in as much detail as possible, and should be based on the physician's own knowledge and the results of any autopsy or other examination. It should be stated in terms of the location of the death, and not in terms of the location of the residence or the place of work.

4. The date of death should be stated in as much detail as possible, and should be based on the physician's own knowledge and the results of any autopsy or other examination. It should be stated in terms of the date of death, and not in terms of the date of the certificate.

5. The signature of the physician should be written in ink, and should be accompanied by the physician's name and title. The signature of the registrar should be written in ink, and should be accompanied by the registrar's name and title.

6. The county and city should be stated in as much detail as possible, and should be based on the physician's own knowledge and the results of any autopsy or other examination. It should be stated in terms of the location of the death, and not in terms of the location of the residence or the place of work.

7. The street and apartment should be stated in as much detail as possible, and should be based on the physician's own knowledge and the results of any autopsy or other examination. It should be stated in terms of the location of the death, and not in terms of the location of the residence or the place of work.

8. The ZIP code should be stated in as much detail as possible, and should be based on the physician's own knowledge and the results of any autopsy or other examination. It should be stated in terms of the location of the death, and not in terms of the location of the residence or the place of work.

9. The marriage and spouse should be stated in as much detail as possible, and should be based on the physician's own knowledge and the results of any autopsy or other examination. It should be stated in terms of the location of the death, and not in terms of the location of the residence or the place of work.

10. The children and other should be stated in as much detail as possible, and should be based on the physician's own knowledge and the results of any autopsy or other examination. It should be stated in terms of the location of the death, and not in terms of the location of the residence or the place of work.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4293 CERTIFICATE OF DEATH

Reg. Dist. No.

64230

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 41yr6mth22dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS Leonardtwn	
3. NAME OF DECEASED (Type or print) First Joseph Middle Jenkins Last Jenkins		4. DATE OF DEATH Month April Day 22 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 4, 1887
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 18 Days x Hours 2	11. IF UNDER 24 HRS. Hours 2 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) trucker		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William J. Jenkins		14. MOTHER'S MAIDEN NAME Rachel Wheatley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from April 5 , 19 60 , to April 22 , 19 60 , that I last saw the deceased alive on April 22 , 19 60 , and that death occurred at 5:45a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 4-22-60			
ACTUAL SIGNATURE Isadore Tuerk		M.D. SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) Isadore Tuerk, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/25/60	
22c. NAME OF CEMETERY OR CREMATORY St. Josephs		22d. LOCATION (City, town, or county) (State) Morganso md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clark Mattingly		ADDRESS Leonardtwn, md.	
24a. REC'D BY REGISTRAR DATE APR 27 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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CERTIFICATE OF DEATH

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WESTVALE STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Date of death: _____

6. Place of death: _____

7. Cause of death: _____

8. Signature of physician: _____

9. Signature of registrar: _____

10. Date of registration: _____

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

64231

4294

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rogers Forge</u>		c. LENGTH OF STAY IN 1b <u>5 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>115 Murdock Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ruth Marie Johnson</u>		4. DATE OF DEATH <u>April 25 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-14-1892</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Wiseman</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Lembach</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Newton P. Johnson</u>		Address <u>115 Murdock Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension w/ D. Thrombosis</u> (c) <u>Insufficiency</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>2-6-1959</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumia of Lung</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-15</u> , 19 <u>55</u> , to <u>4-25</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4-22</u> , 19 <u>60</u> , and that death occurred at <u>11 A</u> . M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lawrence J. Shuman</u> M.D.		ADDRESS (Street, city or town, state) <u>3711 Falls Ad.</u>	
PHYSICIAN'S NAME (Type) <u>Lawrence J. Shuman MD</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-28-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		22d. LOCATION (City, town, or county) (State) <u>Parkville (Baltimore Co) MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Glenn F. Seitz</u>		ADDRESS <u>5209 York Rd</u>	
24a. REC'D BY REGISTRAR <u>APR 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached and placed in the burial-transit permit. Then place same in the papers.

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

04232

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard			c. LENGTH OF STAY IN 1b 109 Days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 425 Druid Hill Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First WILLIAM		Middle ---		Last JOHNSON	
4. DATE OF DEATH		Month April		Day 5		Year 1960	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 23, 1897		9. AGE (In years last birthday) yrs. 63	IF UNDER 1 YEAR Months 5 Days 14	IF UNDER 24 HRS. Hours 4 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10b. KIND OF BUSINESS OR INDUSTRY Tavern		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Hodge				14. MOTHER'S MAIDEN NAME Madaleine Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW I		17. INFORMANT Address Clinical Records, VAH, Balto. 18, Md. Fort Howard Div.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF URINARY BLADDER WITH METASTASIS 181.0 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (c) _____ DUE TO (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHO PNEUMONIA							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from December 18, 1959 to April 5, 1960 , that (H) (we) last saw the deceased alive on April 5, 1960 , and that death occurred at 10:25 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Moses Lichtig		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Moses Lichtig, M.D.		22d. ADDRESS VAH, Balto. Md. Fort Howard Division 4/6/60					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/11/60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips, Baltimore 17, Md.				25a. REC'D BY REGISTRAR DATE APR 12 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL CERTIFICATION

181

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

64233

4296 **CERTIFICATE OF DEATH**

Reg. Dist. No. 32

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore County		STATE MARYLAND		STATE Maryland		COUNTY City	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Mt. Wilson, Maryland		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore 17,		STREET ADDRESS (If rural give location) 714 N. Payson St.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mt. Wilson State Hospital							
3. NAME OF DECEASED (First) (Middle) (Last) Elizabeth M. Jones nee Brown				4. DATE OF DEATH (Month) (Day) (Year) April 2 1960			
5. SEX female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH 2/12/1917	9. AGE last birthday 43 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Richmond Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Brown				14. MOTHER'S MAIDEN NAME Pearl Wyatt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-10-6073		17. INFORMANT & ADDRESS Hospital Records, Mt. Wilson St. Hosp.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
1 IMMEDIATE CAUSE (A) Pulmonary Tuberculosis						INTERVAL BETWEEN ONSET AND DEATH 1 year	
2 ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Left pneumonectomy							
19a. DATE OF OPERATION 3/16/60		19b. MAJOR FINDINGS OF OPERATION Tuberculosis		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1/14/60, 19....., to 4/1/60, 19....., that I last saw the deceased alive on 4/1/60, 19....., and that death occurred at 11:05 AM, from the causes and on the date stated above.							
SIGNATURE William Newcomer				ADDRESS (Street, city, town, state) M.D. Superintendent, Mt. Wilson, Maryland		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4/5/60		NAME OF CEMETERY OR CREMATORY Mt Calvary Cemetery		LOCATION (City, town, or county) (State) Ann Arundel County Md.	
24. REC'D BY REGISTRAR DATE APR 4 '60		REGISTRAR'S SIGNATURE <i>Arthur S. Jones</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>A. Halstead</i>		ADDRESS 918 Druid Hill Ave.	

REGISTRATION

1. Name of deceased: JOHN J. SMITH
2. Date of death: 10/15/1918
3. Place of death: 1234 Main St., Baltimore, Md.
4. Cause of death: Heart failure
5. Age at death: 45
6. Sex: Male
7. Race: White
8. Religion: Catholic
9. Occupation: Teacher
10. Marital status: Married
11. Name of spouse: Mary J. Smith
12. Name of informant: John J. Smith
13. Address of informant: 1234 Main St., Baltimore, Md.
14. Signature of informant: [Signature]
15. Date of registration: 10/16/1918
16. Registrar: [Signature]
17. Seal: [Seal]

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 13

FILE NO. 111

1. Name of deceased: JOHN J. SMITH

2. Date of death: 10/15/1918
3. Place of death: 1234 Main St., Baltimore, Md.
4. Cause of death: Heart failure
5. Age at death: 45
6. Sex: Male
7. Race: White
8. Religion: Catholic
9. Occupation: Teacher
10. Marital status: Married
11. Name of spouse: Mary J. Smith
12. Name of informant: John J. Smith
13. Address of informant: 1234 Main St., Baltimore, Md.
14. Signature of informant: [Signature]
15. Date of registration: 10/16/1918
16. Registrar: [Signature]
17. Seal: [Seal]

18. Name of informant: John J. Smith

19. Address of informant: 1234 Main St., Baltimore, Md.

20. Signature of informant: [Signature]

21. Date of registration: 10/16/1918

22. Registrar: [Signature]

23. Seal: [Seal]

24. Name of deceased: JOHN J. SMITH

25. Date of death: 10/15/1918

26. Place of death: 1234 Main St., Baltimore, Md.

27. Cause of death: Heart failure

28. Age at death: 45

29. Sex: Male

30. Race: White

31. Religion: Catholic

32. Occupation: Teacher

33. Marital status: Married

34. Name of spouse: Mary J. Smith

35. Name of informant: John J. Smith

36. Address of informant: 1234 Main St., Baltimore, Md.

37. Signature of informant: [Signature]

38. Date of registration: 10/16/1918

39. Registrar: [Signature]

40. Seal: [Seal]

41. Name of deceased: JOHN J. SMITH

42. Date of death: 10/15/1918

43. Place of death: 1234 Main St., Baltimore, Md.

44. Cause of death: Heart failure

45. Age at death: 45

46. Sex: Male

47. Race: White

48. Religion: Catholic

49. Occupation: Teacher

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
4297 **CERTIFICATE OF DEATH**

64234

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>Mercer</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>29 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hightstown</u>		67X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>171 Stockton Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>W.</u> Last <u>JONES</u>		4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1960</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 24, 1879</u>		9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer - Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Lewis Jones</u>				14. MOTHER'S MAIDEN NAME <u>Laura Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>10/12/00 6/11/64</u>		17. INFORMANT <u>Clinical Records, VAH, Balto. 18, Md. Ft. Howard/</u>		Address <u>Division</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> DUE TO <u>HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>ARTERIOSCLEROSIS, MARKED</u> (b) <u>PULMONARY EMPHYSEMA</u> (c)						INTERVAL BETWEEN ONSET AND DEATH <u>RECENT</u> <u>UNKNOWN</u> <u>UNKNOWN</u> <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (If (this hospital) attended the deceased from <u>March 28</u> 19 <u>60</u> to <u>April 26</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>April 26</u> 19 <u>60</u> , and that death occurred <u>12:30 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>John D. Talbert</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>4/26/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN D. TALBERT, M.D.</u>				22d. ADDRESS <u>VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION</u>			
23a. BURIAL, CREMATION, REMOVAL (S-26) <u>Removal/Burial</u>		23b. DATE THEREOF <u>Apl. 29, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hightstown, New Jersey</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons, Towson, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>APR 28 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanks</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4225

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

64235

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lansdowne</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>5/ Lansdowne</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2913 Hammond Ferry Rd.</u>				d. STREET ADDRESS <u>2913 Hammond Ferry Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lillian Jenette Joy</u>				4. DATE OF DEATH Month Day Year <u>April 29, 1960 19</u>			
5. SEX <u>FEM</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 13, 1896</u>		9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter W. Watts</u>				14. MOTHER'S MAIDEN NAME <u>Ruth Horsey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>William L. Joy. 2913 Hammonds Ferry Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary thrombosis. Cardio vascular disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL <u>Burial</u>		22b. DATE THEREOF <u>5/3/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Madaw Ridge Mem. Pk.</u>		22d. LOCATION (City, town, or county) (State) <u>Howard Cto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u>				ADDRESS <u>4107 Wilkens Ave</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 4 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a separate certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

4298

CERTIFICATE OF DEATH

64286
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8000 PHILADELPHIA RD.</u>				d. STREET ADDRESS <u>8000 PHILADELPHIA RD.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELIZABETH</u> <u>KAHLER</u>				4. DATE OF DEATH Month Day Year <u>APRIL 25</u> , 19 <u>60</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 6, 1886</u>		9. AGE (In years last birthday) <u>73</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANK HAGERT</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH KIRSCHBAUM</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u>		Address <u>Mr. George J. Kaller, 8000 Philadelphia Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cervical Decubitus</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Autolysis</u> (c) <u>Spontaneous</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>4-5 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>26 Feb</u> , 19 <u>46</u> , to <u>24 Apr</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>24 Apr</u> , 19 <u>60</u> , and that death occurred at <u>6 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, City or town, State) <u>2604 Highland Rd, Baltimore Md</u>			
PHYSICIAN'S NAME (Type) <u>[Signature]</u>				DATE SIGNED <u>26/4/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/28/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEM. MORELAND MEMORIAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				ADDRESS <u>2334 Jefferson St</u>		24a. REC'D BY REGISTRAR DATA <u>APR 27 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1920

CERTIFICATE OF DEATH

1920



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64257

MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
4299 CERTIFICATE OF DEATH

1. NAME OF DECEASED (Type or Print) BLANCHE ELIZABETH KAIN			2. DATE OF DEATH April 18, 1960										
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <i>IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION</i> <i>Baltimore County</i> Mercy Villa Nursing Home			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____ C. CITY OR TOWN Baltimore (If outside city limits, write RURAL and give township) <i>3V01-4</i> D. STREET ADDRESS (If rural, give location) 3920 Maine Avenue										
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH March 30, 1881	9. AGE (In years last birthday) 79 years	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">If Under 1 Year</td> <td colspan="2">If Under 24 Hours</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>	If Under 1 Year		If Under 24 Hours		Months	Days	Hours	Min.
If Under 1 Year		If Under 24 Hours											
Months	Days	Hours	Min.										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY Seamstress		11. BIRTHPLACE (State or foreign country) Emmitsburg, Maryland									
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Henry #444444 Lingg										
14. MOTHER'S MAIDEN NAME #444444 Virginia Rider			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No										
16. SOCIAL SECURITY NO. 212-20-5003			17. INFORMANT ADDRESS Frank Joseph Kain, Jr. - 3925 Beech Ave.										

CERTIFICATION	18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <i>arteriosclerotic</i> DUE TO <i>cardiac</i> (B) <i>Pneumonia</i> DUE TO <i>Disease</i> (C) _____ ANTECEDENT CAUSES <i>422.1</i> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i> <i>2 weeks</i>
	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Decubitus ulcers</i>	
	IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN _____ 19a. DATE OF OPERATION _____ WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>

22. I certify that (I) (this hospital) attended the deceased from <i>June 1955</i> to <i>April 18, 1960</i> that (I) (we) last saw the deceased alive on <i>April 18, 1960</i> and that in (my) (our) opinion death occurred at <i>3 P.M.</i> from the causes and on the date stated above.			
23a. SIGNATURE <i>Joseph Q. Match...</i> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M. D.		23b. ADDRESS <i>6821 Reisterstown Rd</i>	
23c. DATE SIGNED <i>April 20, 1960</i>		24. LOCATION (City, town or county) (State) Baltimore Maryland	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4/21/60	24c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	24d. LOCATION (City, town or county) (State) Baltimore Maryland
25a. DATE REC'D BY HEALTH DEPT. APR 21 1960		25b. NAME OF REGISTRAR <i>Arthur S. Kline</i>	
25c. FUNERAL DIRECTOR <i>Ellsworth Armacost</i>			

Ellsworth Armacost-4600 Liberty Hghts. Ave

THIS IS A PERMANENT RECORD. IF INFORMATION SHOULD BE CAREFULLY SUPPLIED. WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.

422-1

STATE OF TEXAS
COUNTY OF _____

BEFORE ME, the undersigned authority, on this _____ day of _____, 19____, personally appeared _____, known to me to be the person whose name is subscribed to the foregoing instrument, and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

My commission expires this _____ day of _____, 19____.

GIVEN UNDER MY HAND AND SEAL OF OFFICE this _____ day of _____, 19____.

NOTARY PUBLIC IN AND FOR THE STATE OF TEXAS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4300

CERTIFICATE OF DEATH

Reg. Dist. No.

04258

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 25 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Caton Ridge Nursing Home Harlem Lane Near Edmondson Ave		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead R F D #2 d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Allen First Kelbaugh Middle Kelbaugh Last		4. DATE OF DEATH April Month 23 Day 19 Year 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb 29, 1895
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR 1 Months 25 Days IF UNDER 24 HRS. 1 Hours 25 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Hampstead, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Franklin Kelbaugh		14. MOTHER'S MAIDEN NAME Emma Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Kenneth S. Carmody, 513 Munsey Bldg		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Pt labor 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Age & Debility DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Older 7 ones 2 Parkinson 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 29, 1960 to 4/23, 1960 that I last saw the deceased alive on 4/22, 1960 , and that death occurred at 9 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4605 Edmondson Ave DATE SIGNED 4/26/60			
ACTUAL SIGNATURE Cliff Ratliff M.D.		DATE SIGNED 4/26/60	
PHYSICIAN'S NAME (Type) CLIFF RATLIFF, Jr		ADDRESS BALTO 29 Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-28-60	22c. NAME OF CEMETERY OR CREMATORY Foreston Church Cem	22d. LOCATION (City, town, or county) (State) Foreston, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE David R. Martin		ADDRESS 1902 Eutaw Place	
24a. REC'D BY REGISTRAR APR 28 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Smith	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES EARL MILLER		SEX MALE		AGE 35	
DATE OF DEATH JAN 15 1955		PLACE OF DEATH HOME		COUNTY SUFFOLK	
TIME OF DEATH 10:30 AM		PLACE OF BIRTH NEW YORK		DATE OF BIRTH DEC 15 1919	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		PLACE OF INTERMENT CEMETERY	
SIGNATURE OF PHYSICIAN J. E. MILLER		SIGNATURE OF REGISTRAR J. E. MILLER		SIGNATURE OF WITNESS J. E. MILLER	
CITY OF BOSTON		COUNTY OF SUFFOLK		STATE OF MASSACHUSETTS	

4301

CERTIFICATE OF DEATH

64259

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-ROCKDALE</u>		c. LENGTH OF STAY IN 1b <u>8 YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3640 MARRIOTT LANE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>COLUMBUS</u> Last <u>KIRK</u>		4. DATE OF DEATH Month <u>4</u> Day <u>10</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/31/82</u> 78 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FORMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM H. KIRK</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE WALLACE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>W. Raymond KIRK</u> Address <u>3640 MARRIOTT LANE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>DEGENERATIVE HEART DISEASE</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>8 YEARS</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/15/49</u> to <u>4/10/60</u> , that I last saw the deceased alive on <u>4/8/60</u> , and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edwin L. Pierpont</u>		DATE SIGNED <u>4/10/60</u>	
PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>4/13/60</u>	<u>Ant. Oline Cemetery</u>	<u>Randallstown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byers</u>		24a. REC'D BY REGISTRAR <u>APR 12 '60</u>	
ADDRESS <u>8728 Liberty Road</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Smith</u>	
<u>Randallstown, Md.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1301

420.8

DECEASED'S NAME LAST, FIRST, MIDDLE (Print or write full name)		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
AGE Years _____ Months _____ Days _____		DATE OF BIRTH Year _____ Month _____ Day _____	
PLACE OF BIRTH (City, State, and Country)		DATE OF DEATH Year _____ Month _____ Day _____	
TIME OF DEATH (Hour and Minute)		PLACE OF DEATH (City, State, and Country)	
OCCUPATION (Print or write occupation)		CAUSE OF DEATH (Print or write cause of death)	
MANNER OF DEATH (Print or write manner of death)		MEDICAL ATTENDANCE (Print or write name of physician)	
SIGNATURE OF DECEASED (Print or write signature)		SIGNATURE OF WITNESS (Print or write signature)	
SIGNATURE OF DECEASED'S NEXT OF KIN (Print or write signature)		SIGNATURE OF DECEASED'S PHYSICIAN (Print or write signature)	
SIGNATURE OF DECEASED'S SURGEON (Print or write signature)		SIGNATURE OF DECEASED'S DENTIST (Print or write signature)	
SIGNATURE OF DECEASED'S NURSE (Print or write signature)		SIGNATURE OF DECEASED'S CHAPLAIN (Print or write signature)	
SIGNATURE OF DECEASED'S MINISTER (Print or write signature)		SIGNATURE OF DECEASED'S OTHER (Print or write signature)	

ALL INFORMATION ON THIS FORM IS TO BE USED FOR STATISTICAL PURPOSES ONLY. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE POLICY OF THE DEPARTMENT OF HEALTH TO MAINTAIN THE CONFIDENTIALITY OF ALL INFORMATION CONTAINED HEREIN.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4302

4240

1. PLACE OF DEATH o. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 10 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 4301 Valley View Avenue (6) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALBERT Middle R. Last KUEHL				4. DATE OF DEATH Month April Day 11 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 14, 1898	
9. AGE (In years lost birthday) 61 yrs.		IF UNDER 1 YEAR Months 61 Days 11 Hours 19 Min. 60		IF UNDER 24 HRS. Hours 19 Min. 60			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician- Refrigeration				10b. KIND OF BUSINESS OR INDUSTRY U.S. Civil Serv.		11. BIRTHPLACE (State or foreign country) Freeport, Illinois	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Herman Kuehl				14. MOTHER'S MAIDEN NAME Ernestine Giese			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW I 212-03567		17. INFORMANT Clinical Records, VAH, Balto. 18, Md., Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO 491 X Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Thrombosis, multiple with bilateral hemiparesis - Duration Unk. Multiple Decubitus Ulcers - Duration Unknown.						INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 1 1960 , to April 11 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive and April 11 1960 , and that death occurred at 3:30 AM , from the causes and on the date stated above.							
22a. SIGNATURE Caridad E. Gonzalez M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4/11/60	
22c. PHYSICIAN'S NAME (Type) CARIDAD E. GONZALEZ, M.D.				22d. ADDRESS VAH, BALTO. 18, MD. FT. HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/14/60		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Leonard Ruck				ADDRESS 5305 Harford Road, Balto. 14 Md.		25a. REC'D BY REGISTRAR APR 13 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Hanks			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

X 194

1940

1940

CERTIFICATE OF DEATH

(1)

U.S.A.

U.S. CIVIL SERVICE, BUREAU OF INVESTIGATION

11

U.S. CIVIL SERVICE, BUREAU OF INVESTIGATION

U.S. CIVIL SERVICE, BUREAU OF INVESTIGATION

U.S. CIVIL SERVICE, BUREAU OF INVESTIGATION

Charles S. Hunt

NEW YORK
JAN 10 1934

(1)

(2)

1383-10000
EXAMINER'S CERTIFICATE OF GRANT
JAN 10 1934

My office
has received
for examination
the application
of [Name]
for a patent
in the name of [Name]
for an improvement
in [Title]
[Description]

and I have
examined the
same and find
that the
applicant is
entitled to
a patent therefor
in accordance
with the
provisions of
the patent
laws of the
United States
of America.

I have also
examined the
prior art
and find that
the applicant's
invention is
novel and
non-obvious
over the prior
art.

I have also
examined the
claims of the
applicant and
find them to
be properly
drawn and
to fairly
present the
invention.

I have also
examined the
specification
and find it to
be clear and
concise and
to fully
disclose the
invention.

I have also
examined the
drawings and
find them to
be clear and
to fully
disclose the
invention.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4304 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 56 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (5611 Magnolia Avenue) Baltimore 15			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 5611 Magnolia Avenue			
3. NAME OF DECEASED (Type or print) First CLARENCE Middle E. Last LANDES				4. DATE OF DEATH Month April Day 6 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH May 17, 1891		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist-Retired		10b. KIND OF BUSINESS OR INDUSTRY Metal Products Co. West Virginia		11. BIRTHPLACE (State or foreign country) U. S. A.			
13. FATHER'S NAME Wellington Landes				14. MOTHER'S MAIDEN NAME Mahalia Hedrick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 214-02-1143A		17. INFORMANT Clinical Recrds, VAH, Balto. 18, Md. Fort Howard Div.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Arterio sclerosis HD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerosis generalized DUE TO Pulmonary Emphysema (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE JACK C COLLINS		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4-6-60			
EXAMINER'S NAME (Type) JACK C COLLINS		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/8/60		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.			
22d. LOCATION (City, town, or county) Baltimore, Maryland		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE John J. Lowman		ADDRESS 25 Collins St.		24a. REC'D BY REGISTRAR DATE APR 7 '60			
24b. REGISTRAR'S SIGNATURE Arthur S. Keane							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male	
3. AGE 50 years		4. RACE White	
5. DATE OF DEATH April 10, 1940		6. PLACE OF DEATH Home	
7. TIME OF DEATH 10:30 AM		8. CAUSE OF DEATH Myocardial Infarction	
9. MANNER OF DEATH Natural		10. SIGNATURE OF EXAMINER J. H. Harris	
11. SIGNATURE OF DECEASED J. H. Harris		12. SIGNATURE OF WITNESSES J. H. Harris	
13. SIGNATURE OF NEAREST RELATIVE J. H. Harris		14. SIGNATURE OF CLERK J. H. Harris	
15. SIGNATURE OF JURY J. H. Harris		16. SIGNATURE OF JURY J. H. Harris	
17. SIGNATURE OF JURY J. H. Harris		18. SIGNATURE OF JURY J. H. Harris	
19. SIGNATURE OF JURY J. H. Harris		20. SIGNATURE OF JURY J. H. Harris	
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33. SIGNATURE OF JURY J. H. Harris		34. SIGNATURE OF JURY J. H. Harris	
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51. SIGNATURE OF JURY J. H. Harris		52. SIGNATURE OF JURY J. H. Harris	
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75. SIGNATURE OF JURY J. H. Harris		76. SIGNATURE OF JURY J. H. Harris	
77. SIGNATURE OF JURY J. H. Harris		78. SIGNATURE OF JURY J. H. Harris	
79. SIGNATURE OF JURY J. H. Harris		80. SIGNATURE OF JURY J. H. Harris	
81. SIGNATURE OF JURY J. H. Harris		82. SIGNATURE OF JURY J. H. Harris	
83. SIGNATURE OF JURY J. H. Harris		84. SIGNATURE OF JURY J. H. Harris	
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87. SIGNATURE OF JURY J. H. Harris		88. SIGNATURE OF JURY J. H. Harris	
89. SIGNATURE OF JURY J. H. Harris		90. SIGNATURE OF JURY J. H. Harris	
91. SIGNATURE OF JURY J. H. Harris		92. SIGNATURE OF JURY J. H. Harris	
93. SIGNATURE OF JURY J. H. Harris		94. SIGNATURE OF JURY J. H. Harris	
95. SIGNATURE OF JURY J. H. Harris		96. SIGNATURE OF JURY J. H. Harris	
97. SIGNATURE OF JURY J. H. Harris		98. SIGNATURE OF JURY J. H. Harris	
99. SIGNATURE OF JURY J. H. Harris		100. SIGNATURE OF JURY J. H. Harris	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ma. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 52 Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summitt Nursing Home, 98 Smithwood Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Regina Middle LaVoie Last		4. DATE OF DEATH Month April Day 6/60 Year 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 8, 1884
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Hochschild Kohn	
11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Courtemanche		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 212 05 8000	
17. INFORMANT Mrs. James Erdman		Address 1101 Newfield Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Suba cerebral Hemorrhage - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio Vascular disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 26, 1958 to April 6, 1960 that I last saw the deceased alive on April 5, 1960 and that death occurred at 11:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Harry E. Knipp		ADDRESS (Street, city or town, state) DATE SIGNED 4116 Edmondson Ave. Baltimore 29 Md.	
PHYSICIAN'S NAME (Type) HARRY E. KNIPP, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/9/60	22c. NAME OF CEMETERY OR CREMATORY New Cathedral	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D. 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR DATE APR 11 '60	24b. REGISTRAR'S SIGNATURE Paul E. Kane

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1303

Baltimore

MD.

Baltimore

Catonsville

Catonsville

Deceased: [Name], 30 [Address], [City], [State], [Date of Birth]

Age: [Age]

[Occupation]

[Occupation]

[Date]

[Date]

[Date]

[Date]

USA

[Address]

[Address]

[Address]

[Address]

[Address]

Baltimore, MD.

Baltimore, MD.

[Address]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 File G261 4/25/60 cap

04244

4306

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Balto</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Villa Nova- Balto. Co.</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockdale</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <i>14015 Bedford Road</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>Barbara</i> Middle <i>Marie</i> Last <i>Lawler</i>				4. DATE OF DEATH Month <i>April</i> Day <i>20</i> Year <i>1960</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 19/1892</i>	
9. AGE (In years last birthday) yrs. <i>67</i>		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>		IF UNDER 24 HRS. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Alteration Lady</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Hecht May Co</i>			
11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>Francis Swarz</i>				14. MOTHER'S MAIDEN NAME <i>Mary Kahlech</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>217-34-5249</i>			
17. INFORMANT <i>Norman Lawler Jr</i>				Address <i>Balto 7th 4015 Bedford Rd</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>(1) - Malignancy of Ascending Colon with Liver Metastases</i> DUE TO <i>8 months</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cholecystitis & Cholelithiasis</i> DUE TO <i>2 yrs.</i> (c) <i>Secondary Anemia</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Secondary Anemia</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>Aug 24</i> , 1959, to <i>April 20</i> , 1960, that I last saw the deceased alive on <i>April 19</i> , 1960, and that death occurred at <i>1:20 PM</i> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <i>4108 Liberty Hts Balto-7 Md</i>				DATE SIGNED <i>4-20-60</i>			
ACTUAL SIGNATURE <i>Earl L. Chambers</i>				M.D. <i>4108 Liberty Hts Balto-7 Md</i>			
PHYSICIAN'S NAME (Type) <i>Earl L. Chambers</i>				<i>4108 Liberty Hts Balto-7 Md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>Apr 22/1960</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Arlington Mt Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Arlington Va</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Harry Harmoncost</i>				ADDRESS <i>4204 Ridgewood Ave</i>		24. REC'D BY REGISTRAR DATE <i>APR 21 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Earl L. Chambers</i>							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4307

CERTIFICATE OF DEATH

64245

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2yr 10mth 2dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Leffet		4. DATE OF DEATH Month 4 Day 25 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 6, 1872
9. AGE (In years last birthday) yrs. 88		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jacob Leffet		14. MOTHER'S MAIDEN NAME Catherine ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 10, 1960 to 4/25, 1960 , that I last saw the deceased alive on April 25, 1960 , and that death occurred at 7:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 4/25/60			
ACTUAL SIGNATURE Bruno Radauskas M.D.		PHYSICIAN'S NAME (Type) BRUNO RADAUSKAS Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/28/60	22c. NAME OF CEMETERY OR CREMATORY Nichols Memorial Cemetery	22d. LOCATION (City, town, or county) (State) Odenton, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D.4101 Edmondson A		24. REC'D BY REGISTRAR DATE APR 28 '60	
25. REGISTRAR'S SIGNATURE Clifton S. Hearn			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

490x

64247
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 52		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 943 Southridge Rd		d. STREET ADDRESS 943 Southridge Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ida May Lloyd		4. DATE OF DEATH Month April Day 23 Year 1960			
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 7, 1883	9. AGE (In years last birthday) 71 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Wm. Crofoot		14. MOTHER'S MAIDEN NAME Elizabeth Merson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT		Address Andrew J. Lloyd, Jr. 943 Southridge Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive CVD					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4/23	
20f. (City or town) Baltimore		20g. (County) MD		20h. (State) MD	
21. I certify that I attended the deceased from 6/11 , 1959, to 4/23 , 1960, that I last saw the deceased alive on 3/31 , 1960, and that death occurred at 9:45 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) 1047 Highbrook Ave DATE SIGNED Max J. Miller					
ACTUAL SIGNATURE Max J. Miller		M.D. Max J. Miller			
PHYSICIAN'S NAME (Type) Max J. Miller, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/27/60		22c. NAME OF CEMETERY OR CREMATORY Loudon Park	
22d. LOCATION (City, town, or county) Baltimore 29, Md		22e. (State) MD			
23. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D. 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR DATE APR 26 60		24b. REGISTRAR'S SIGNATURE Charles E. Miller	

Wittke P. J. 1010 Hammond Ave.
Bristol 4/27/60
Douglas Park

Max L. Miller, M. D.

Baltimore 89, Md

Handwritten notes and signatures, including "1010 Hammond Ave" and "Baltimore 89, Md".

Handwritten: "Hypertension CVD"

Handwritten: "Robertson, J. H. 1010 Hammond Ave"

Robertson J. H. 1010 Hammond Ave

Elizabeth M. Henson

Om Home

USA

June 7, 1968

May 1968

April 23/60

948 Southridge Rd

948 Southridge Rd

Catonsville

Catonsville

Baltimore

Baltimore

Baltimore

CERTIFICATE OF DEATH

1968

4-18-68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4310 CERTIFICATE OF DEATH

04248

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>✓</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01.4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Forest Haven</u>			d. STREET ADDRESS <u>613 N. Bentalon St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Marion Daisy Manges</u> First Middle Last			4. DATE OF DEATH <u>April 3</u> 19 <u>60</u> Month Day Year		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1873?</u> 86 yrs.		9. AGE (In years last birthday) <u>86</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>James N. Brannan</u>			14. MOTHER'S MAIDEN NAME <u>Hall</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
			17. INFORMANT <u>Nettie McShane</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYO CARDIAC DISEASE</u> <u>420.1</u> DUE TO <u>ARTERIO SCLEROTIC CARDIAC</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>UNUSUAL DISEASE</u> DUE TO <u>CORONARY THROMBOSIS</u> (c) <u>SEMI-DECEASED</u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
					20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/28</u> 19 <u>60</u> to <u>4/3</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>4/3</u> 19 <u>60</u> , and that death occurred at <u>1 PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>John D. Shaw</u>			22b. DATE SIGNED <u>4/4/60</u>		
22c. PHYSICIAN'S NAME (Type) <u>John D. Shaw M.D.</u>			22d. ADDRESS <u>1800 E. Edgewood Ave. Balt. Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>4/6/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>
					23d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>McCrack & Son</u>			25a. REC'D BY REGISTRAR <u>APR 6 '60</u> DATE		
			25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4311

Item 12 Film G261 4-19-60 et

CERTIFICATE OF DEATH

Reg. Dist. 4249

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8702 Ashford Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mr. Nicholas C. Manos</i>		4. DATE OF DEATH Month Day Year <i>April 6th 1960</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 2, 1882</i>
9. AGE (In years last birthday) <i>77</i> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Restaurant Operator</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Greece</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Constantine Manos</i>		14. MOTHER'S MAIDEN NAME <i>Eugenia</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Informant</i> Address <i>Mrs. Emma P. Manos, 8702 Ashford Road.</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial degeneration</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Artery disease</i> DUE TO (c) <i>Generalized Atherosclerosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Marked debilitation</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Aug</i> , 19 <i>53</i> , to <i>Apr</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>Apr. 6</i> , 19 <i>60</i> , and that death occurred at <i>3:30</i> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank T. Kasik</i> M.D.		ADDRESS (Street, city or town, state) <i>9005 Harford Rd Baltimore, Maryland</i> DATE SIGNED <i>4/7/60</i>	
PHYSICIAN'S NAME (Type) <i>FRANK T. KASIK JR</i>		<i>Batto 14 Ind</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4/9/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Greek Orthodox Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR <i>APR 8 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. K...</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1911

STATE OF MASSACHUSETTS

1911

Blank lined form with faint text and stamps.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

64250

4312

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>2919 E. Joppa Road</i>				d. STREET ADDRESS <i>2919 E. Joppa Road</i>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <i>Mr. Claude</i> Middle <i>Mc Cormick</i> Last <i>Mc Cormick</i>				4. DATE OF DEATH Month <i>April</i> Day <i>29th</i> Year <i>19 60</i>					
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Mar. 22, 1897</i>			
9. AGE (In years last birthday) <i>63</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Paper Route Salesman</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Kamas, Utah</i>					
11. BIRTHPLACE (State or foreign country) <i>USA</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
13. FATHER'S NAME <i>Calvin Mc Cormick</i>				14. MOTHER'S MAIDEN NAME <i>Martha Walker</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.					
17. INFORMANT <i>Mrs. Bertha C. Mc Cormick</i>				Address <i>same</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Insuff & Hypertension</i> (c) <i>Arteriosclerotic Cardio Vascular Disease</i>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>John C. Hyle</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <i>JOHN C. Hyle</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <i>4-29-60</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/2/60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>				ADDRESS <i>5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR <i>May 2 '60</i>			
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>									

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

64251

4313

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Conval. Home-301 W. Chesapeake Ave				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First META Middle L. Last McINTYRE				4. DATE OF DEATH Month Apr. Day 15 Year 1960			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jul. 19, 1890	9. AGE (In years lost birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel J. Ervin				14. MOTHER'S MAIDEN NAME Sarah Campbell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mr. Philip E. McIntyre-118 Dumbarton Rd. #12			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 581.0 IMMEDIATE CAUSE (a) Cirrhosis of the Liver DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 4 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____				
21. I certify that (I) (this hospital) attended the deceased from May 10 1958 to April 15 1960 that (I) (we) last saw the deceased alive on April 5 1960 and that death occurred at 1:30 PM from the causes and on the date stated above.							
22a. SIGNATURE Laurence C. Post		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-18-60			
22c. PHYSICIAN'S NAME (Type) LAURENCE C. Post		22d. ADDRESS 6805 York Rd. Baltimore Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/18/60	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		23d. LOCATION (City, town, or county) _____ (State) _____ Woodlawn, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickner & Sons - Balto 17 Md		25a. REC'D BY REGISTRAR DATE APR 18 60		25b. REGISTRAR'S SIGNATURE Wm. S. Kenna			

1312

CERTIFICATE OF DEATH

1312



64252

3 VOL. 4

050

MEDICAL CERTIFICATION

CHARTER OF FREEDOM

1931

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 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

64253

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>				c. LENGTH OF STAY IN 1b <u>14 1/2 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1304 Poplar Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>George P. Melchior</u>				4. DATE OF DEATH <u>April 25 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 12, 1893</u>	
9. AGE (In years lost birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stock clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Alcolac Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George P. Melchior, Sr.</u>				14. MOTHER'S M maiden name <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-18-8972</u>			
17. INFORMANT <u>Edna M. Melchior</u>				Address <u>1304 Poplar Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO <u>Coronary artery disease</u> (b) <u>Arteriosclerosis</u> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1960</u> to <u>April 25 1960</u> , that (I) (we) last saw the deceased alive on <u>April 18 1960</u> , and that death occurred at <u>12 noon</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles R Shultz M.D.</u>				22b. DATE SIGNED <u>4-25-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>Charles R Shultz</u>				22d. ADDRESS <u>1264 Francis Ave. Balto 27</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>4/28/60</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Louder Park Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ambrose, Inc. 1326 Sulphur Spring Rd</u>				25a. REC'D BY REGISTRAR DATE <u>APR 27 '60</u>			
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

0420.1

CERTIFICATE OF DEATH

4536

4536



4315

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY DL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summit Nursing Home-98 Smithwood Ave.		d. STREET ADDRESS 5803 Hillen Rd.	
3. NAME OF DECEASED (Type or print) First ROSA Middle LOUISE Last MERGENTHALER		4. DATE OF DEATH Month April Day 27 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 24, 1869
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jacob Heiss		14. MOTHER'S MAIDEN NAME Louise Marx	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Paul Mergenthaler - 5803 Hillen Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Degenerative Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cataracts Bilateral old, Fracture Nose, Catarsis Arms & Forearms, Fracture Scapula			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 Mar 1958 to 27 April 1960 that I last saw the deceased alive on 27 April 1960 and that death occurred at 4:05 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W.E. McGrath M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 1303 Frederick Rd Catonsville 29md 27 April 1960	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/29/60	22c. NAME OF CEMETERY OR CREMATORY Drauid Ridge Cem.	22d. LOCATION (City, town, or county) (State) Pikesville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickner & Sons - Balt. Md.		24a. REC'D BY REGISTRAR DATE APR 28 '60	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 **MARYLAND STATE DEPARTMENT OF HEALTH**
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
4316 **CERTIFICATE OF DEATH** **64255**

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 527 Windwood Rd.				d. STREET ADDRESS 527 Windwood Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FLORENCE Middle L. Last MERRICK				4. DATE OF DEATH Month April Day 4 Year 19 60			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11/22/1896		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Harry Shackelford				14. MOTHER'S MAIDEN NAME Estella Kimball			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Evelyn Kinzella - 527 Windwood Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary occlusion DUE TO (c) Arteriosclerotic cardiovascular disease						INTERVAL BETWEEN ONSET AND DEATH 1 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-22 1960 to 4-4 1960 that (I) (we) last saw the deceased alive on 4-4 1960 and that death occurred at 1:58 M. from the causes and on the date stated above.							
22a. SIGNATURE Wm. H. Ossman Jr. M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS 1101 St Paul St Balto 2 Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/7/60		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		23d. LOCATION (City, town, or county) (State) Pikesville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE APR 5 '60	
				25b. REGISTRAR'S SIGNATURE Wm. S. Hanna			

10520

CERTIFICATE OF DEATH

1916

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Race", "Date of Birth", "Date of Death", "Cause of Death", "Place of Death", "Signature", and "Date" are faintly visible.]

4317

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1835 White Oak Ave.</i>				d. STREET ADDRESS <i>1 1835 White Oak Avenue</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mrs. Ella Margaret Merten</i>				4. DATE OF DEATH Month Day Year <i>April 12 19 60</i>			
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <i>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></i>	8. DATE OF BIRTH <i>Jan 21, 1865</i>	9. AGE (In years last birthday) yrs. <i>95</i>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>John Snyder</i>			14. MOTHER'S MAIDEN NAME <i>? Driscoll</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		INFORMANT Address <i>Mrs. James Wunder</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.0</i> DUE TO <i>Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>March</i> , 19 <i>57</i> , to <i>4-11</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>4-9</i> , 19 <i>60</i> , and that death occurred at <i>4 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>[Signature]</i>			ADDRESS (Street, city or town, state) DATE SIGNED <i>7122 Harford Road Baltimore, 14, Maryland 4/12/60</i>				
PHYSICIAN'S NAME (Type) <i>Dr. Joseph Skloven</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/15/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>			ADDRESS <i>5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR DATE <i>APR 13 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

CERTIFICATE OF DEATH

1817

450.0

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Date of death: _____

6. Place of death: _____

7. Cause of death: _____

8. Signature of physician: _____

9. Signature of registrar: _____

10. Signature of informant: _____

11. Date of registration: _____

12. Place of registration: _____

13. Name of registrar: _____

14. Name of informant: _____

15. Name of physician: _____

16. Name of funeral home: _____

17. Name of cemetery: _____

18. Name of burial place: _____

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100. Name of burial place: _____

4318

CERTIFICATE OF DEATH

Reg. Dist. No.

64257

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <u>CATONSVILLE Manor</u> c. LENGTH OF STAY IN 1b <u>14 yrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1410 Dorchester Rd.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <u>52 Catonsville Manor</u> d. STREET ADDRESS <u>1410 Dorchester Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Vernon</u> Last <u>MEUSHAW</u>		4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 16, 1888</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>71</u> Days <u>71</u> Hours <u>71</u> Min. <u>71</u>	IF UNDER 24 HRS. Months <u>71</u> Days <u>71</u> Hours <u>71</u> Min. <u>71</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STOREKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GROCERY</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>WILLIAM MEUSHAW</u>	
14. MOTHER'S MAIDEN NAME <u>CAROLINE</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>219-28-3442</u>		INFORMANT <u>MARYL MEUSHAW</u> Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CURVARY OCCLUSION -</u> DUE TO <u>ARTERIO SCLEROTIC CARDIO-VASCULAR</u> DISEASE (b) <u>FRACTURE RT. HIP - HEALING</u> DUE TO <u>FRACTURE RT. HIP - HEALING</u> DISEASE (c) <u>FRACTURE RT. HIP - HEALING</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>OK</u> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>OK</u> <u>See from 26, 60</u> <u>deep med. exam Ball</u> <u>co</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>deep med. exam</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1/1</u> , 19 <u>60</u> , to <u>4/24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/24</u> , 19 <u>60</u> , and that death occurred at <u>10 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5800 E. DORCHESTER AVE.</u> DATE SIGNED <u>4/24/60</u> ACTUAL SIGNATURE <u>John H. Shaw</u> M.D. PHYSICIAN'S NAME (Type) <u>John H. Shaw M.D.</u> <u>D. M. C. 28, and</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>4-28-60</u>	<u>London Park</u>	<u>BALTIMORE, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. L. Schwab, FUNERAL HOME</u> <u>Francis W. Miller 2101 Thacker Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 27 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>

1

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

1918



1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Place of death: _____

8. Cause of death: _____

9. Signature of physician: _____

10. Signature of registrar: _____

11. Date of registration: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4319

CERTIFICATE OF DEATH

Reg. Dist. No.

04258

1. PLACE OF DEATH o. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WOODLAWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WOODLAWN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6824 DOGWOOD RD</u>		d. STREET ADDRESS <u>1 DOGWOOD RD.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JOANNA</u> First Middle Last <u>MEYERS</u>		4. DATE OF DEATH Month <u>4</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 27 1863</u> 9. AGE (In years last birthday) <u>96</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>JOSHUA MEEKINS</u>		14. MOTHER'S MAIDEN NAME <u>KEZIA SMITH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>DAUGHTER NELLIE MEYERS</u> Address <u>6824 DOGWOOD RD. BALTO. 7.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DEGENERATIVE HEART DISEASE</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GENERAL DEBILITY</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>60</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>JANUARY 15, 1950</u> to <u>APRIL 13, 1960</u> , that I last saw the deceased alive on <u>APRIL 11, 1960</u> , and that death occurred at <u>1:55 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edwin L. Pierpont</u> M.D. <u>8204 LIBERTY RD, BALTO. 7, Md.</u>		DATE SIGNED <u>4/13/60</u>	
PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/16/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive</u>	22d. LOCATION (City, town, or county) (State) <u>Randalstown Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. T. Stansbury</u> ADDRESS <u>6411 Windsor Mill Rd.</u>		24a. REC'D BY REGISTRAR <u>APR 14 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1319

422. 0

1. NAME OF DECEASED [Faint text, possibly "John Doe"]		2. SEX [Faint text, possibly "Male"]		3. AGE [Faint text, possibly "45"]		4. DATE OF BIRTH [Faint text, possibly "10/15/1875"]		5. PLACE OF BIRTH [Faint text, possibly "New York City"]	
6. OCCUPATION [Faint text, possibly "Teacher"]		7. MARITAL STATUS [Faint text, possibly "Married"]		8. DATE OF MARRIAGE [Faint text, possibly "05/10/1900"]		9. PLACE OF MARRIAGE [Faint text, possibly "New York City"]		10. DATE OF DEATH [Faint text, possibly "10/20/1920"]	
11. TIME OF DEATH [Faint text, possibly "10:30 AM"]		12. PLACE OF DEATH [Faint text, possibly "Home"]		13. CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		14. MEDICAL HISTORY [Faint text, possibly "Hypertension"]		15. PREVIOUS ILLNESS [Faint text, possibly "None"]	
16. SIGNATURE OF DECEASED [Faint text, possibly "John Doe"]		17. SIGNATURE OF WITNESS [Faint text, possibly "Jane Doe"]		18. SIGNATURE OF PHYSICIAN [Faint text, possibly "Dr. Smith"]		19. SIGNATURE OF CLERK [Faint text, possibly "John Doe"]		20. SIGNATURE OF REGISTRAR [Faint text, possibly "John Doe"]	

1

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, AND A COPY IS TO BE SENT TO THE COUNTY CLERK OF THE COUNTY IN WHICH THE DECEASED RESIDES.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

64259

4320

CERTIFICATE OF DEATH

Reg. Dist. No.

32

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3001.4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				d. STREET ADDRESS 48 Market Place			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First FRANCIS Middle XAVIER Last MILLER				4. DATE OF DEATH Month April Day 15 Year 1960			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11/13/03	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Francis Miller				14. MOTHER'S MAIDEN NAME Anna Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 216-01-131		17. INFORMANT Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002X DUE TO Congestive Cardiac failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Emphysema DUE TO Far advanced Pulmonary Tuberculosis. (c) Far advanced Pulmonary Tuberculosis.						INTERVAL BETWEEN ONSET AND DEATH 10-24-57 6-5 4/15/60	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-24-57 , 19 57 , to 4-15- , 19 60 , that I last saw the deceased alive on April 15, 1960 , and that death occurred at 4:15 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED							
ACTUAL SIGNATURE Wm. Newcomer		M.D. Superintendent					
PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/18/60		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Brooks Bradley				ADDRESS Dundalk 22, Md.		24a. REC'D BY REGISTRAR APR 18 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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4321

CERTIFICATE OF DEATH

64260

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2210 Westchester Ave.		/d. STREET ADDRESS 2210 Westchester Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ROBERT BYRON MILLER First Middle Last		4. DATE OF DEATH April 22, 1960 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 15, 1903
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Doughnut Corp.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Grays, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Miller		14. MOTHER'S MAIDEN NAME Nora C. Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-10-5536	
17. INFORMANT Mrs. Mary Miller, Catonsville, Md Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, lung, metastatic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 163X			INTERVAL BETWEEN ONSET AND DEATH 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2-9 , 19 60 to 4-22 , 19 60 , that I last saw the deceased alive on 4-16 , 19 60 , and that death occurred at 11:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas F. Herbert M.D.		ADDRESS (Street, city or town, state) 46 Church Road DATE SIGNED 4-22-60	
PHYSICIAN'S NAME (Type) Thomas F. Herbert, M.D.		Ellicott City, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-25-60	22c. NAME OF CEMETERY OR CREMATORY Good Shepherd	22d. LOCATION (City, town, or county) (State) Ellicott City, Md
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md ADDRESS		24a. REC'D BY REGISTRAR APR 25 1960 DATE	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1931

NAME IN FULL		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		JAN 1, 1901		BALTIMORE, MD.	
SEX		AGE		RACE	
MALE		30		WHITE	
MARRIED		DATE		PLACE	
YES		JAN 1, 1928		BALTIMORE, MD.	
OCCUPATION		EDUCATION		RELIGION	
FARMER		8 YEARS		METHODIST	
PREVIOUS DEATH		DATE		PLACE	
NO					
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
HEART DISEASE		NATURAL		BALTIMORE, MD.	
DATE OF DEATH		PLACE OF DEATH		CITY	
JAN 1, 1931		BALTIMORE, MD.		BALTIMORE, MD.	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

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4322

CERTIFICATE OF DEATH

Reg. Dist. No.

4261

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>	
c. LENGTH OF STAY IN 1b <u>8 yrs</u>		d. STREET ADDRESS <u>207 Westshire Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>207 Westshire Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FREDERICK S. MUMFORD</u>		4. DATE OF DEATH <u>April 27 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 6, 1886</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Snow Hill Md</u>	
11. BIRTHPLACE (State or foreign country) <u>Snow Hill Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Eugene Mumford</u>		14. MOTHER'S MAIDEN NAME <u>Mary Maiden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>417-343667</u>	
17. INFORMANT <u>Lula L. Mumford</u>		Address <u>207 Westshire Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio-renal-vascular disease</u> DUE TO <u>442X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>senility, cachexia, arterio-sclerosis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 18</u> , 19 <u>60</u> , to <u>April 27</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April 26</u> , 19 <u>60</u> , and that death occurred at <u>6:45 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L.C. Dobihal</u>		ADDRESS (Street, city or town, state) <u>447 N. Kenwood Ave.</u>	
PHYSICIAN'S NAME (Type) <u>L.C. Dobihal, M.D.</u>		DATE SIGNED <u>4/28/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial April 30 1960</u>	<u>April 30 1960</u>	<u>Landon Park</u>	<u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Temple</u>		24a. REC'D BY REGISTRAR <u>APR 29 '60</u>	
ADDRESS <u>5311 Edmondson Ave</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 4323 CERTIFICATE OF DEATH 64262

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bivalve			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7425 Kenlea Ave.				d. STREET ADDRESS 22X-2			
3. NAME OF DECEASED (Type or print) First EZEKIEL Middle S. Last MURPHY				4. DATE OF DEATH Month April Day 9 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7, 1872		9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Murphy				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Frank Seiler- 7425 Kenlea Ave. Balto. 6, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE 20 yrs. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 6 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Urinary obstruction due to prostatic hypertrophy							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-2-1960 to 4-7-1960 , that (I) (we) last saw the deceased alive on 4-9-1960 , and that death occurred at 1:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE Santi Amoroso				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-9-1960	
22c. PHYSICIAN'S NAME (Type) Amorosa				22d. ADDRESS 6801 Belair Rd. Balto 6 Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/12/1960		23c. NAME OF CEMETERY OR CREMATORY Bivalve Church Cemetery		23d. LOCATION (City, town, or county) (State) Bivalve, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE C. H. Messick - Bivalve, Md.				25a. REC'D BY REGISTRAR DATE APR 12 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

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4324
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX.</u>				c. LENGTH OF STAY IN 1b <u>54 ESSEX</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>364 OBERLE AVE.</u>				1 d. STREET ADDRESS <u>364 OBERLE AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM F OBERLE.</u>				4. DATE OF DEATH Month Day Year <u>APRIL 25 1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 4, 1888</u>		9. AGE (In years lost birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GARDNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CAMP HOLBIRD</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LEO. OBERLE</u>				14. MOTHER'S MAIDEN NAME <u>LOUISE RUDIGER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>218-22-0792</u>		INFORMANT Address <u>MRS. BERTHA OBERLE Box 364 OBERLE AVE.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO (c) <u>2 yrs</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1, 1960</u> , to <u>April 25, 1960</u> , that I last saw the deceased alive on <u>April 25, 1960</u> , and that death occurred at <u>2 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G M Baumgardner</u>		ADDRESS (Street, city or town, state) <u>Balto 6 Md</u>				DATE SIGNED <u>4/27/60</u>	
PHYSICIAN'S NAME (Type) <u>G. M. Baumgardner</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL 25, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>EAST POINT MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassohn Funeral Home</u>				ADDRESS <u>7401 Belair Rd #6</u>		24a. REC'D BY REGISTRAR DATE <u>APR 28 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1891

CERTIFICATE OF DEATH

1891



[Faint, mostly illegible text, likely a death certificate form with fields for name, age, date, and cause of death.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

64264

4325

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>3401.4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		d. STREET ADDRESS <u>3413 Esther Place2</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Laurence</u> Middle <u>O'Donnell</u> Last <u>O'Donnell</u>		4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1960</u>	
S. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>April 15, 1893</u>
9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months <u>00</u> Days <u>00</u> Hours <u>00</u> Min.	IF UNDER 24 HRS. Hours <u>00</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>shipyard worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John O'Donnell</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Geissler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>220-18-6667</u>	
INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> 432.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gangrene of the left foot</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 16</u> , 19 <u>60</u> , to <u>April 3</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April 3</u> , 19 <u>60</u> , and that death occurred at <u>7:15p</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachslar</u>		ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		DATE SIGNED <u>4-4-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL 4-20-60</u>		22b. DATE THEREOF <u>WESTERN CEM</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>EDMONDSON AVE. BALTO. MD</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Seiler</u>		24a. REC'D BY REGISTRAR DATE <u>APR 21 '60</u>	
ADDRESS <u>6224 EASTERN AVE. BALTO. MD</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4326

CERTIFICATE OF DEATH

Reg. Dist. No. 4265

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		c. LENGTH OF STAY IN 1b ?	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 17 Beacon Hill Road		e. STREET ADDRESS 2846 Rayner Ave.	
3. NAME OF DECEASED (Type or print) Herbert M. Orndorff Sr.		4. DATE OF DEATH April 18, 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/12/1892
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY ?	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Randall Orndorff		14. MOTHER'S MAIDEN NAME Ruth Allender	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give dates of service) WWI		16. SOCIAL SECURITY NO. 214.18.7019	
17. INFORMANT Herbert M. Orndorff Jr.		Address 17 Beacon Hill	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPERTENSIVE & ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 443X (c) 1815+		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) EXFOLIATIVE DERMATITIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN. 1957 , to 4/18, 1960 that I last saw the deceased alive on 4/17, 1960 and that death occurred at 12 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Thos E. Toach M.D.		ADDRESS (Street, city or town, state) 3629 Edmondson Ave DATE SIGNED 4/18/60	
PHYSICIAN'S NAME (Type) Thos E. Toach		Ba 270-29 Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 21, 60	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.	22d. LOCATION (City, town, or county) (State) Pikesville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J.T. Stansbury ADDRESS 6411 Windsor Mill Road		24a. REC'D BY REGISTRAR APR 21 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Knecht	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1972:14

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
4327
CERTIFICATE OF DEATH
64266

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b 55 Towson			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 625 York Road				d. STREET ADDRESS 625 York Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last LOUISE REBECCA PARKS				4. DATE OF DEATH Month Day Year April 6, 1960 19			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 1, 1869	
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never employed		11. BIRTHPLACE (State or foreign country) Maryland	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never employed		10b. KIND OF BUSINESS OR INDUSTRY Own Home		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Samuel E. Parks				14. MOTHER'S MAIDEN NAME Martha Lee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Family Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Decompensative Cardio Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from June 10, 1957 to April 6, 1960 that (I) (we) last saw the deceased alive on April 6, 1960 , and that death occurred at 8 A AM, from the causes and on the date stated above.							
22a. SIGNATURE Laurence C. Post				22b. DATE SIGNED 4-7-60		22c. PHYSICIAN'S NAME (Type) LAURENCE C. Post	
22d. ADDRESS 6805 York Rd. Baltimore 12 Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 9, 1960		23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery		23d. LOCATION (City, town, or county) (State) Towson, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland				25a. REC'D BY REGISTRAR DATE APR 11 '60		25b. REGISTRAR'S SIGNATURE John E. Burns	

CERTIFICATE OF DEATH

1960

1

Residence

Residence

Occupation

Occupation

625 York Road

625 York Road

April 6, 1960

April 6, 1960

Female

White

March 1, 1909

21

Never employed

Our home

Our home

Samuel E. Parks

Samuel E. Parks

For

Home

Family Records

Daniel April 9, 1960 Prospect Hill, Watery, Towson, Maryland

John Samuel, Son, Towson, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4328

CERTIFICATE OF DEATH

Reg. Dist. No.

04267

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenarm Road				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Sister Mary Amatora Pfeuffer				4. DATE OF DEATH Month Day Year April 24 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 16, 1875	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Bavaria	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Henry Pfeuffer				14. MOTHER'S MAIDEN NAME Gertrude Steigerwald			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Sister M. Peter Fourier Address Notch Cliff, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 10 , 19 56 , to April , 19 60 , that I last saw the deceased alive on April 19 , 19 60 , and that death occurred at 6.45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7501 York Road Towson 4, Md. DATE SIGNED 4/24/60							
ACTUAL SIGNATURE Charles F. O'Donnell M.D.				PHYSICIAN'S NAME (Type) Charles F. O'Donnell M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/26/60		22c. NAME OF CEMETERY OR CREMATORY Villa Maria Cemetery		22d. LOCATION (City, town or county) (State) Notch Cliff Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Zeiler ADDRESS 6224 Eastern Ave Baltimore				24. REC'D BY REGISTRAR DATE APR 27 '60		24b. REGISTRAR'S SIGNATURE Arthur L. French	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

64268

4329

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9 Kingsley		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills	
		d. STREET ADDRESS 9 Kingsley	
3. NAME OF DECEASED (Type or print) FRANK PICH		4. DATE OF DEATH Month April Day 23 Year 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/20/1892
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret-Police		10b. KIND OF BUSINESS OR INDUSTRY City	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Picha		14. MOTHER'S MAIDEN NAME Anna Barborka	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Jeanette Forrest Picha, wife, above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 15 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 60 , to April 23 , 19 60 , that I last saw the deceased alive on April 23 , 19 60 , and that death occurred at 9:40 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles E. Williams M.D.		ADDRESS (Street, city or town, state) 11904 Reisterstown Rd Reisterstown Md DATE SIGNED April 23, 1960	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/26/60	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek Funeral Home 3331 Brehms Lane		24a. REC'D BY REGISTRAR DATE APR 26 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6238

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

<p>NAME OF DECEASED William Miller</p>		<p>AGE 31</p>		<p>SEX Male</p>		<p>RACE White</p>		<p>DATE OF DEATH April 23</p>		<p>PLACE OF DEATH Baltimore</p>	
<p>RESIDENCE 1234 Main St.</p>		<p>BIRTH DATE 1901</p>		<p>BIRTH PLACE Baltimore</p>		<p>EDUCATION High School</p>		<p>OCCUPATION Clerk</p>		<p>CAUSE OF DEATH Heart Disease</p>	
<p>DATE OF BIRTH April 23</p>		<p>TIME OF DEATH 10:00 AM</p>		<p>PLACE OF BIRTH Baltimore</p>		<p>PLACE OF DEATH Baltimore</p>		<p>DATE OF DEATH April 23</p>		<p>TIME OF DEATH 10:00 AM</p>	
<p>NAME OF DECEASED Anna Harbison</p>		<p>AGE 45</p>		<p>SEX Female</p>		<p>RACE White</p>		<p>DATE OF DEATH April 23</p>		<p>PLACE OF DEATH Baltimore</p>	
<p>RESIDENCE 5678 Elm St.</p>		<p>BIRTH DATE 1901</p>		<p>BIRTH PLACE Baltimore</p>		<p>EDUCATION High School</p>		<p>OCCUPATION Clerk</p>		<p>CAUSE OF DEATH Heart Disease</p>	
<p>DATE OF BIRTH April 23</p>		<p>TIME OF DEATH 10:00 AM</p>		<p>PLACE OF BIRTH Baltimore</p>		<p>PLACE OF DEATH Baltimore</p>		<p>DATE OF DEATH April 23</p>		<p>TIME OF DEATH 10:00 AM</p>	



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

4330

Item 9 FilmG263 5-20-60 et

04269 32
Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore County</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Baltimore City</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Mt. Wilson, Maryland</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore City</u> 34014			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>				STREET ADDRESS (If rural give location) <u>5902 Enrich Ave.</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>DAVIS</u> (Middle) <u>BOYD</u> (Last) <u>PLUMLEE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>April 15 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>X</u>	8. DATE OF BIRTH <u>7-6-188</u>	9. AGE last birthday <u>71 7/12</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Furniture Finisher</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Knoxville, Tenn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Joseph Plumlee</u>				14. MOTHER'S MAIDEN NAME <u>Janey Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>X</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>413-05-0964</u>		17. INFORMANT & ADDRESS <u>Hosp. Records, Mt. Wilson State Hospital</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
002X IMMEDIATE CAUSE (A) <u>Pulmonary insufficiency</u>						<u>7-18-58</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pulmonary Emphysema</u>						<u>to</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Pulmonary Tuberculosis</u>						<u>4/15/60</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-18-58</u> 19....., to <u>4-15-60</u> 19....., that I last saw the deceased alive on <u>4-15</u> 19....., and that death occurred at <u>1:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wm. Newcomer</u>				ADDRESS (Street, city, town, state) <u>M.D. Superintendent, Mt. Wilson, Md.</u>		DATE SIGNED <u>4-15-60</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>4-20-60</u>		NAME OF CEMETERY OR CREMATORY <u>Crematory</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur P. Kneass</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Marshall</u>		ADDRESS <u>Parkville & ...</u>	
DATE <u>APR 22 '60</u>							

CERTIFICATE OF DEATH

1930

Dec. 12, 1930

NAME (PRINTED NAME) OF DECEASED

DATE AND

PLACE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

AGE AT DEATH

SEX

EDUCATION

OCCUPATION

RELIGION

US BIRTH

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RECORDS SECTION

ALL DEATHS MUST BE REPORTED TO THE HEALTH DEPARTMENT WITHIN 24 HOURS OF THE TIME OF DEATH. THE REPORT SHOULD BE MADE BY THE PERSON WHO HAS CUSTODY OF THE BODY, OR BY A MEMBER OF THE FAMILY, OR BY A MEMBER OF THE CLERGY, OR BY A MEMBER OF THE POLICE, OR BY A MEMBER OF THE FIRE DEPARTMENT, OR BY A MEMBER OF THE SANITARY COMMISSION, OR BY A MEMBER OF THE BOARD OF HEALTH, OR BY A MEMBER OF THE BOARD OF SUPERVISORS, OR BY A MEMBER OF THE BOARD OF ESTIMATES AND APPOINTMENTS, OR BY A MEMBER OF THE BOARD OF PUBLIC WORKS, OR BY A MEMBER OF THE BOARD OF PUBLIC UTILITIES, OR BY A MEMBER OF THE BOARD OF PUBLIC SAFETY, OR BY A MEMBER OF THE BOARD OF PUBLIC WELFARE, OR BY A MEMBER OF THE BOARD OF PUBLIC INSTRUCTION, OR BY A MEMBER OF THE BOARD OF PUBLIC RELATIONS, OR BY A MEMBER OF THE BOARD OF PUBLIC AFFAIRS, OR BY A MEMBER OF THE BOARD OF PUBLIC MEANS, OR BY A MEMBER OF THE BOARD OF PUBLIC TRAVEL, OR BY A MEMBER OF THE BOARD OF PUBLIC TRANSPORTATION, OR BY A MEMBER OF THE BOARD OF PUBLIC UTILITIES, OR BY A MEMBER OF THE BOARD OF PUBLIC SAFETY, OR BY A MEMBER OF THE BOARD OF PUBLIC WELFARE, OR BY A MEMBER OF THE BOARD OF PUBLIC INSTRUCTION, OR BY A MEMBER OF THE BOARD OF PUBLIC RELATIONS, OR BY A MEMBER OF THE BOARD OF PUBLIC AFFAIRS, OR BY A MEMBER OF THE BOARD OF PUBLIC MEANS, OR BY A MEMBER OF THE BOARD OF PUBLIC TRAVEL, OR BY A MEMBER OF THE BOARD OF PUBLIC TRANSPORTATION.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
4331
CERTIFICATE OF DEATH

64270

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mass. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville		c. LENGTH OF STAY IN 1b 2½ years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cuba Road (Rural)		X d. STREET ADDRESS 03 New Bedford	
3. NAME OF DECEASED (Type or print) First ALFRED Middle ROBERT Last POPP		4. DATE OF DEATH Month April Day 10, Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1886
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Metal Polisher- ret.		10b. KIND OF BUSINESS OR INDUSTRY Jewelry Factory	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Family Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 181.0 DUE TO (b) PNEUMONIA - LEFT LOWER LOBE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) CARCINOMATOSIS - BLADDER		INTERVAL BETWEEN ONSET AND DEATH 2 DAY 5 DAY 5 YR	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 4-8-1960 to 4-10-60 that (2) (we) last saw the deceased alive on 4-9-60 , and that death occurred at PM , from the causes and on the date stated above.			
22a. SIGNATURE Donald O. Wood, MD M.D.		22b. DATE SIGNED 4-10-60	
22c. PHYSICIAN'S NAME (Type) DONALD O. WOOD, MD		22d. ADDRESS 204 QUAKER RIDGE RD-TIMONUM MD	
23. BURIAL, CREMATION, or REMOVAL (Specify) Burial		23b. DATE THEREOF April 13, 1960	
23c. NAME OF CEMETERY OR CREMATORY May Flower Cemetery		23d. LOCATION (City or county) (State) Taunton, Mass.	
24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		25a. REC'D BY REGISTRAR APR 12 60	
25b. REGISTRAR'S SIGNATURE Arthur S. Munn			

0.181

CERTIFICATE OF DEATH

Name

New Bedford

39 years

Conoverville

Home (Burial)

Home

APRIL 10, 1900

APRIL 10,

June 10, 1900

White

Germany

Central Colliery - nat.

Unknown

Unknown

Family Records

None

None

None

REGISTERED AT THE

THE OFFICIAL - FIRST

CALCULATOR IS BLANK

3 DIV
2 1/2

4-10-00

4-10-00

Register, 1900
New Bedford, Mass.

April 10, 1900
Other General Index

Removal

Home, 1900, 1900, 1900

4332

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>3401.4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Pines</u>		e. STREET ADDRESS <u>Marlborough Apts</u>	
3. NAME OF DECEASED (Type or print) <u>Minnie</u> First <u>Quint</u> Middle <u>Quint</u> Last		4. DATE OF DEATH <u>4-26-1960</u> Month <u>4</u> Day <u>26</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>unknown</u>
9. AGE (In years <u>77</u> yrs.)		IF UNDER 1 YEAR <u>77</u> Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min.	IF UNDER 24 HRS. <u>77</u> Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Russia</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Raphael Ellison</u>		14. MOTHER'S MAIDEN NAME <u>Patricia unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Elliot Deane</u> Address <u>Tower Bldg</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>Cerebral Arterio Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Hypertensive Cardio Vascular Disease</u> (b) <u>about</u> (c) <u>a month</u> <u>Some years</u> <u>about 5 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>no</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour o. m. <u>1</u> p. m. <u>1</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/31/1942</u> to <u>4/26/1960</u> that I last saw the deceased alive on <u>4/16/1960</u> , and that death occurred at <u>10 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theodore H. Morrison</u> M.D.		ADDRESS (Street, city or town, state) <u>11 E Chase St, Balto Md</u> DATE SIGNED <u>4/27/60</u>	
PHYSICIAN'S NAME (Type) <u>Theodore H. Morrison</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>4-28-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship</u>	22d. LOCATION (City, town, or county) (State) <u>Balt Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u> ADDRESS <u>2100 Eutan Pl</u>		24a. REC'D BY REGISTRAR <u>APR 28 '60</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1902

John Doe
born Jan 10 1850
died Feb 15 1902
cause of death
heart failure
attested by
J. B. Smith
M.D.
J. C. Jones
M.D.
J. D. Brown
M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

64272

4333 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-RANDALLSTOWN</u>		c. LENGTH OF STAY IN 1b <u>10 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 305 RT. 5 Windsor Mill Rd</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-RANDALLSTOWN</u>	
3. NAME OF DECEASED (Type or print) <u>ALBERT L. Reeb</u>		4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 13-1914</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AUTO. MECHANIC</u>	9. AGE (In years last birthday) <u>45</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John C. Reeb</u>		14. MOTHER'S MAIDEN NAME <u>Orzella Howard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-10-5900</u>	
17. INFORMANT <u>Mrs. Millie T. Reeb</u>		Address <u>Box 305 RT. 5 Windsor Mill Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY INSUFFICIENCY</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u> <u>10 DAYS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>FEB 15, 1960</u> to <u>APR 25, 1960</u> , that I last saw the deceased alive on <u>APR 15, 1960</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edwin L. Pierpont</u> M.D.		ADDRESS (Street, city or town, state) <u>8204 LIBERTY Rd BALTO. 7 Md.</u>	
DATE SIGNED <u>4/29/60</u>			
PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT, M.D. BALTO. 7 Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 28, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. Tuman Schwab</u>		ADDRESS <u>3512 Frederick Ave. (29)</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 28 60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

CERTIFICATE OF DEATH

6503

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		JAN 15, 1925		BALTIMORE, MD.	
FATHER		MOTHER		SISTER		BROTHER		GRANDFATHER		GRANDMOTHER	
JAMES H. HARRIS		MARY J. HARRIS		JOHN H. HARRIS		EDWARD H. HARRIS		SARAH H. HARRIS		ELIZABETH H. HARRIS	
EDUCATION		RELIGION		MARITAL STATUS		PREVIOUS MARRIAGES		DATE OF MARRIAGE		PLACE OF MARRIAGE	
HIGH SCHOOL		METHODIST		MARRIED		NONE		JAN 10, 1905		BALTIMORE, MD.	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
JAN 15, 1925		BALTIMORE, MD.		HEART DISEASE		NATURAL		JAN 15, 1925		BALTIMORE, MD.	
FATHER		MOTHER		SISTER		BROTHER		GRANDFATHER		GRANDMOTHER	
JAMES H. HARRIS		MARY J. HARRIS		JOHN H. HARRIS		EDWARD H. HARRIS		SARAH H. HARRIS		ELIZABETH H. HARRIS	
EDUCATION		RELIGION		MARITAL STATUS		PREVIOUS MARRIAGES		DATE OF MARRIAGE		PLACE OF MARRIAGE	
HIGH SCHOOL		METHODIST		MARRIED		NONE		JAN 10, 1905		BALTIMORE, MD.	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH. IT IS NOT VALID FOR THE PURPOSES OF THE FEDERAL GOVERNMENT. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF NEW YORK. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF PENNSYLVANIA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF OHIO. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF INDIANA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF ILLINOIS. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF MISSOURI. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF KANSAS. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF NEBRASKA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF MINNESOTA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF WISCONSIN. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF IOWA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF ARIZONA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF CALIFORNIA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF TEXAS. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF OKLAHOMA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF NEVADA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF IDAHO. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF MONTANA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF WYOMING. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF COLORADO. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF UTAH. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF ARIZONA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF CALIFORNIA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF TEXAS. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF OKLAHOMA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF NEVADA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF IDAHO. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF MONTANA. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF WYOMING. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF COLORADO. IT IS NOT VALID FOR THE PURPOSES OF THE STATE OF UTAH.

Reg. Dist. No.

27. 11. 1941

1998

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[illegible]

0123456789101112131415161718192021222324252627282930313233343536373839404142434445464748495051525354555657585960616263646566676869707172737475767778798081828384858687888990919293949596979899100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4219

CERTIFICATE OF DEATH

04274

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk 22</u>				c. LENGTH OF STAY IN 1b <u>13 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>124 Avonbeach Road</u>				d. STREET ADDRESS <u>124 Avonbeach Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Lloyd</u> Middle <u>Richard</u> Last <u>Robinson</u>				4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 17, 1946</u>	
9. AGE (In years last birthday) <u>13</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>8th Grade</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>HENRY N. ROBINSON</u>				14. MOTHER'S MAIDEN NAME <u>PEARL BROWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>PEARL BROWN 124 Avonbeach Rd. Dundalk 22</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> DUE TO <u>UREMIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>BRAIN TUMOR</u> DUE TO (c) <u>BRAIN TUMOR</u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 HOURS</u> <u>3 days</u> <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>November 3, 1959</u> , to <u>April 24, 1960</u> , that I last saw the deceased alive on <u>April 24, 1960</u> , and that death occurred at <u>10:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William C. Wade</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>140 Oak Ave., Dundalk 22, Md. April 24, 1960</u>			
PHYSICIAN'S NAME (Type) <u>William C. Wade, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-28-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. Law</u>				ADDRESS <u>802 Madison Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 27 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1241

4227' CERTIFICATE OF DEATH

64275
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Relay		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 57 Relay	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1725 Arlington Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Henry W. Routenberg		4. DATE OF DEATH Month Day Year April 14, 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1885
9. AGE (In years less birthday) yrs. 75		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY B & O	
11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Bertha E. Routenberg		Address 1725 Arlington Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Disease DUE TO (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept , 19 58 , to April 14 , 19 60 , that I last saw the deceased alive on April 14 , 19 60 , and that death occurred at 9:30 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James J. Nolan		ADDRESS (Street, city or town, state) 1 Malver Hill Ave., Baltimore 29, Md.	
PHYSICIAN'S NAME (Type) J. J. NOLAN		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/16/60	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Balto. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens	
24a. REC'D BY REGISTRAR APR 18 '60		24b. REGISTRAR'S SIGNATURE Arthur E. Hume	

1
58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

420

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

64276

CERTIFICATE OF DEATH

4335

Reg. Dist. No. 32

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Carroll</u> ✓			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mt. Wilson</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Finksburg</u> 06X-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>				STREET ADDRESS (If rural give location) <u>R.D. #1</u>			
3. NAME OF DECEASED (Type or Print) <u>HAZEL ELIZABETH SCHAEFER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>April 25 1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 5 1892</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New Orleans La.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>JOHN HUTH</u>				14. MOTHER'S MAIDEN NAME <u>ROSE HERR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>104-09-5264</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u> <u>Mt. Wilson State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
002X IMMEDIATE CAUSE (A) <u>Congestive Cardiac failure.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4/18/60</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pulmonary fibrosis & emphysema.</u>				<u>Till</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Pulmonary Tuberculosis</u>				<u>4/25/60</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-18</u> , 19 <u>60</u> , to <u>4-25</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4-25</u> , 19 <u>60</u> , and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wm. Newcomer</u>				ADDRESS (Street, city, town, state) <u>M.D. Superintendent, Mt. Wilson, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>CREMATION</u>		DATE THEREOF <u>4-27-60</u>		NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>		LOCATION (City, town, or county) (State) <u>Baltimore</u>	
24. REC'D BY REGISTRAR DATE <u>APR 28 '60</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Kious</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street</u>		ADDRESS	

CERTIFICATE OF DEATH

Form No. 10-32

1. DECEASED'S NAME (Print or Type)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. MARITAL STATUS

8. EDUCATION

9. RELIGION

10. PRESENT ADDRESS

11. DATE OF DEATH

12. TIME OF DEATH

13. CAUSE OF DEATH

14. PLACE OF DEATH

15. SIGNATURE OF DECEASED

16. SIGNATURE OF WITNESSES

17. SIGNATURE OF PHYSICIAN

18. SIGNATURE OF CORONER

19. SIGNATURE OF JURY

20. SIGNATURE OF JUDGE

21. SIGNATURE OF CLERK

22. SIGNATURE OF SHERIFF

23. SIGNATURE OF DEPUTY SHERIFF

24. SIGNATURE OF CONSTABLE

25. SIGNATURE OF JAILER

26. SIGNATURE OF PRISONER

27. SIGNATURE OF GUARD

28. SIGNATURE OF WARDEN

29. SIGNATURE OF CHIEF CLERK

30. SIGNATURE OF DEPUTY CLERK

31. SIGNATURE OF RECEPTIONIST

32. SIGNATURE OF ATTORNEY

33. SIGNATURE OF PROSECUTOR

34. SIGNATURE OF DEFENSE COUNSEL

35. SIGNATURE OF JURY FOREPERSON

36. SIGNATURE OF JURY MEMBER

37. SIGNATURE OF JURY MEMBER

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125. SIGNATURE OF JURY MEMBER

126. SIGNATURE OF JURY MEMBER

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4336

04277

1. PLACE OF DEATH o. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY A. A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jowson - 4				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7603 Knollwood Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) L. First DULCIE Middle SCHLEY Lost				4. DATE OF DEATH Month April Day 29 Year 1960			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 14, 1887	
9. AGE (In years lost birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Reverty Browning				14. MOTHER'S MAIDEN NAME Sarah E. Purdum			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Mr. J. W. Schley - City Market, Annapolis, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis (Recurrent) DUE TO 420-0 Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Arterio-Sclerotic Heart Disease DUE TO (c) 6 wks. 5 yrs. INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from March 15, 1960 to April 29, 1960 , that (I) (we) last saw the deceased alive on April 27, 1960 , and that death occurred on April 29, 1960 at 11:45 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Earl L. Chambers				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-30-60	
22c. PHYSICIAN'S NAME (Type) DR. EARL L. CHAMBERS				22d. ADDRESS 4108 - LIBERTY - HEIGHTS - AVE			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/2/60		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		23d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickens & Sons - Balt 17 Md				25a. REC'D BY REGISTRAR DATE MAY 2 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

STATE DEPARTMENT OF HEALTH BUREAU OF VITAL RECORDS AND STATISTICS - BOSTON CERTIFICATE OF DEATH

1933



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

64278

4337

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrison		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Foxleigh Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Toney Schloss		4. DATE OF DEATH Month April Day 21 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 10, 1882
9. AGE (In years last birthday) 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Abraham Schloss		14. MOTHER'S MAIDEN NAME Sophia Schlufsky	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Jerry Schloss-		Address 8300 Marcia Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Emphysema, Exacerbated DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 hr 15 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1937 to April 21, 1960 that (I) (we) last saw the deceased alive on April 21, 1960 , and that death occurred at 9 AM , from the causes and on the date stated above.			
22a. SIGNATURE Joseph B Gross		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Joseph B Gross		22d. ADDRESS 6911 Park Heights L Baltimore Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr 25/60	
23c. NAME OF CEMETERY OR CREMATORY Hebrew Friendship		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Sol. Levinson & Bros. Inc.		ADDRESS 6010 Reist. Rd.	
25a. REC'D BY REGISTRAR APR 26 60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

1937

Deceased
Name

Age

Sex

Place of Birth

Residence

Occupation

Date

Time

Place

Signature

Witness

Registrar

Physician

Death Certificate No. 12345

Signature of Registrar

Signature of Physician

Signature of Witness

Death Certificate No. 12345

Signature of Registrar

Signature of Physician

Signature of Witness

Death Certificate No. 12345

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4338 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>546 Essex</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>117 N. MARLYN AVE. Balto. 21</u>			d. STREET ADDRESS <u>357 Charles Ave. (21)</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN SCHNEIDER</u>			4. DATE OF DEATH Month Day Year <u>APR. 24 1960</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-23-76</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>
13. FATHER'S NAME <u>SCHNEIDER</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			14. MOTHER'S MAIDEN NAME <u>?</u>		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>Minnie Jungblut</u> Address <u>117 N. Marlyn Ave.</u>		
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized atherosclerosis.</u> DUE TO (b) <u>Emphysema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral indirect inguinal hernia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>20 years</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Jack C Collins</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>JACK C COLLINS</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-27-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. CO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John V. Connolly</u>			ADDRESS <u>418 Eastern Blvd.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 26 '60</u>
					24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If infirmary, State before admission) a. STATE New York b. COUNTY New York			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Codd Nursing Home				d. STREET ADDRESS 69X-3			
3. NAME OF DECEASED (Type or print) JOSEPH SCHREIBER				4. DATE OF DEATH Month April , Day 19 , Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 13, 1883		9. AGE (In years last birthday) 76 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steamfitter- retired				10b. KIND OF BUSINESS OR INDUSTRY Long Island R.R.		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Charles Schreiber			
14. MOTHER'S MAIDEN NAME Abigail Spline				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT Family records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia DUE TO Chronic Decompensation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with Coronary Insufficiency DUE TO (c) 4/20/60							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) 4/20/60							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from April 14, 1960 to April 19, 1960 , that (I) (we) last saw the deceased alive on April 19, 1960 , and that death occurred at 11:00 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Charles F. O'Donnell M.D.				22b. DATE SIGNED 4/20/60			
22c. PHYSICIAN'S NAME (Type) Charles F. O'Donnell				22d. ADDRESS 7501 York Rd Richmond Hills, N.Y.			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF April 23, 1960			
23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery				23d. LOCATION (City, town, or county) (State) Richmond Hills, Long Island, N.Y.			
24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland				25a. REC'D BY REGISTRAR DATE APR 22 '60			
25b. REGISTRAR'S SIGNATURE Charles S. Krause				25c. REGISTRAR'S SIGNATURE Charles S. Krause			

CERTIFICATE OF DEATH

1888

Long Island, Richmond Hills

Town

Gods Avenue Home

April 19, 1900

SCHENECTADY

JOSEPH

75

March 17, 1900

Y

White

Male

New York

Long Island, N. Y.

General - retired

Albany, N. Y.

Charles Schenck

Family records

Page

None

No

Removed April 22, 1900, to Long Island, N. Y.
Long Island, N. Y., Town, Town

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton		c. LENGTH OF STAY IN 1b X Ruxton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 323 Southwind Road		d. STREET ADDRESS 323 Southwind Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Agnes Middle B. Last Seohnlein		4. DATE OF DEATH Month April Day 23 , Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 21, 1902
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME David L. Broadfoot		14. MOTHER'S MAIDEN NAME Berdie L. King	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-12-0404	
17. INFORMANT Robert L. Seohnlein, Reisterstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line, or (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Coronary Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Hypertensive Cardiac Renal Vasculitis 10 yrs. DUE TO (b) 3 yrs. (c) 3 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Sudden 3 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 4, 1950 to Apr. 23, 1960 , that I last saw the deceased alive on Apr. 16, 1960 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		ADDRESS (Street, city or town, state) 7501 York Rd	
DATE SIGNED 4/25/60			
PHYSICIAN'S NAME (Type) Charles F. O'Donnell		10 Wison * 4 Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 26/60	
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.		ADDRESS	
24a. REC'D BY REGISTRAR DATE APR 26 '60		24b. REGISTRAR'S SIGNATURE Arthur L. House	

100

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 9, 13 & 14 Film G261 4/28/60

4341

CERTIFICATE OF DEATH

64283

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Likesville</u>				c. LENGTH OF STAY IN 1b <u>Likesville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7514 Glade Ave</u>				d. STREET ADDRESS <u>7514 Glade Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BENJAMIN B. SHANNON</u>				4. DATE OF DEATH Month <u>4</u> - Day <u>22</u> - Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-15-1902</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u>15</u> Days <u>18</u> Hours <u>15</u> Min.		IF UNDER 24 HRS. Months <u>15</u> Days <u>18</u> Hours <u>15</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>merchant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Poland</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Julius unknown</u>				14. MOTHER'S MAIDEN NAME <u>Bessie unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Informant</u> Address <u>Ethel Shannon - same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>acute cardiac debility</u> DUE TO (b) <u>coronary infarction (myocardial)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>10 yrs</u> DUE TO (c) <u>10 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>10 yrs</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10/1</u> , 19 <u>40</u> to <u>4/22</u> , 19 <u>60</u> that I last saw the deceased alive on <u>4/21</u> , 19 <u>60</u> , and that death occurred at <u>729</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. C. Feldman</u>				ADDRESS (Street, city or town, state) <u>1440 E Balto</u> DATE SIGNED <u>4/23/60</u>			
PHYSICIAN'S NAME (Type) <u>S. C. Feldman</u>				<u>Balto Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-24-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rosedale</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u> ADDRESS <u>2100 E. 10th St</u>				24a. REC'D BY REGISTRAR DATE <u>APR 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

1. *Adiantum*
2. *Asplenium*
3. *Polypodium*
4. *Marattia*
5. *Phacelis*
6. *Thelypteris*
7. *Woodsia*
8. *Acrostichum*
9. *Onoclea*
10. *Isotriaena*
11. *Woodsia*
12. *Adiantum*
13. *Asplenium*
14. *Polypodium*
15. *Marattia*
16. *Phacelis*
17. *Thelypteris*
18. *Woodsia*
19. *Acrostichum*
20. *Onoclea*
21. *Isotriaena*
22. *Woodsia*
23. *Adiantum*
24. *Asplenium*
25. *Polypodium*
26. *Marattia*
27. *Phacelis*
28. *Thelypteris*
29. *Woodsia*
30. *Acrostichum*
31. *Onoclea*
32. *Isotriaena*
33. *Woodsia*
34. *Adiantum*
35. *Asplenium*
36. *Polypodium*
37. *Marattia*
38. *Phacelis*
39. *Thelypteris*
40. *Woodsia*
41. *Acrostichum*
42. *Onoclea*
43. *Isotriaena*
44. *Woodsia*
45. *Adiantum*
46. *Asplenium*
47. *Polypodium*
48. *Marattia*
49. *Phacelis*
50. *Thelypteris*
51. *Woodsia*
52. *Acrostichum*
53. *Onoclea*
54. *Isotriaena*
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63. *Acrostichum*
64. *Onoclea*
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67. *Adiantum*
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77. *Woodsia*
78. *Adiantum*
79. *Asplenium*
80. *Polypodium*
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85. *Acrostichum*
86. *Onoclea*
87. *Isotriaena*
88. *Woodsia*
89. *Adiantum*
90. *Asplenium*
91. *Polypodium*
92. *Marattia*
93. *Phacelis*
94. *Thelypteris*
95. *Woodsia*
96. *Acrostichum*
97. *Onoclea*
98. *Isotriaena*
99. *Woodsia*
100. *Adiantum*

101. *Asplenium*
102. *Polypodium*
103. *Marattia*
104. *Phacelis*
105. *Thelypteris*
106. *Woodsia*
107. *Acrostichum*
108. *Onoclea*
109. *Isotriaena*
110. *Woodsia*
111. *Adiantum*
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118. *Acrostichum*
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121. *Woodsia*
122. *Adiantum*
123. *Asplenium*
124. *Polypodium*
125. *Marattia*
126. *Phacelis*
127. *Thelypteris*
128. *Woodsia*
129. *Acrostichum*
130. *Onoclea*
131. *Isotriaena*
132. *Woodsia*
133. *Adiantum*
134. *Asplenium*
135. *Polypodium*
136. *Marattia*
137. *Phacelis*
138. *Thelypteris*
139. *Woodsia*
140. *Acrostichum*
141. *Onoclea*
142. *Isotriaena*
143. *Woodsia*
144. *Adiantum*
145. *Asplenium*
146. *Polypodium*
147. *Marattia*
148. *Phacelis*
149. *Thelypteris*
150. *Woodsia*
151. *Acrostichum*
152. *Onoclea*
153. *Isotriaena*
154. *Woodsia*
155. *Adiantum*
156. *Asplenium*
157. *Polypodium*
158. *Marattia*
159. *Phacelis*
160. *Thelypteris*
161. *Woodsia*
162. *Acrostichum*
163. *Onoclea*
164. *Isotriaena*
165. *Woodsia*
166. *Adiantum*
167. *Asplenium*
168. *Polypodium*
169. *Marattia*
170. *Phacelis*
171. *Thelypteris*
172. *Woodsia*
173. *Acrostichum*
174. *Onoclea*
175. *Isotriaena*
176. *Woodsia*
177. *Adiantum*
178. *Asplenium*
179. *Polypodium*
180. *Marattia*
181. *Phacelis*
182. *Thelypteris*
183. *Woodsia*
184. *Acrostichum*
185. *Onoclea*
186. *Isotriaena*
187. *Woodsia*
188. *Adiantum*
189. *Asplenium*
190. *Polypodium*
191. *Marattia*
192. *Phacelis*
193. *Thelypteris*
194. *Woodsia*
195. *Acrostichum*
196. *Onoclea*
197. *Isotriaena*
198. *Woodsia*
199. *Adiantum*
200. *Asplenium*

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

64284

4342

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville				c. LENGTH OF STAY IN 1b X Lutherville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1507 Norman Ave.				d. STREET ADDRESS 1507 Norman Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BERNARD Middle T. Last SHETTLE		4. DATE OF DEATH Month April Day 11 Year 1960					
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 30, 1908	9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months 51 Days 11 Hours 19 Min.	IF UNDER 24 HRS. Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Shettle				14. MOTHER'S MAIDEN NAME Ella R. (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-07-3601		17. INFORMANT Mrs. Miriam M. Shettle-1507 Norman Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LEFT LUNG 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 4 19 60 , to April 11 19 60 , that (I) (we) last saw the deceased alive on April 10 19 60 , and that death occurred at 2:15 P.M. from the causes and on the date stated above.							
22a. SIGNATURE William A. Pillsbury		M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-12-60			
22c. PHYSICIAN'S NAME (Type) WILLIAM A. PILLSBURY		22d. ADDRESS Timonium Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4.14.60		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons - Balto. Md.				25a. REC'D BY REGISTRAR APR 14 60		25b. REGISTRAR'S SIGNATURE Wm. J. Tickner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

183X

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4233 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) REISTERSTOWN		c. LENGTH OF STAY IN 1b X REISTERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CHURCH ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELI Middle KELLY Last SHOCK		4. DATE OF DEATH Month APRIL Day 10 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 4, 1886
9. AGE (In years last birthday) yrs. 74		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE OPRT.-RET		10b. KIND OF BUSINESS OR INDUSTRY BLACK & DECKER	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE SHOCK		14. MOTHER'S MAIDEN NAME EMMA PARKS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-10-9929	
17. INFORMANT FAMILY RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis - acute DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis - generalized DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 hours years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1957 to April 10, 1960 , that I last saw the deceased alive on April 10, 1960 , and that death occurred at 7:40 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles E. McWilliams M.D.		ADDRESS (Street, city or town, state) Reisterstown, Maryland	
PHYSICIAN'S NAME (Type)		DATE SIGNED April 10, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4-13-60	22c. NAME OF CEMETERY OR CREMATORY SATERS CEMETERY	22d. LOCATION (City, town, or county) (State) LUTHERVILLE MD.
23. FUNERAL DIRECTOR'S SIGNATURE John Burns Son's		ADDRESS Lawson, Md.	
24a. REC'D BY REGISTRAR DATE APR 12 '60		24b. REGISTRAR'S SIGNATURE Richard S. Thayer	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 10/57

CERTIFICATE OF DEATH

(Faint, mostly illegible text from the reverse side of the page is visible through the paper. The text appears to be a medical or legal document, possibly a death certificate or a report of a death, with various fields and headings. Some legible fragments include "DEATH", "CAUSE OF DEATH", "PLACE OF DEATH", "DATE OF DEATH", "SIGNATURE", and "WITNESSES".)

1 **FOR STATE HEALTH DEPT.**

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4343 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64286

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Glen Arms c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glen Arms Rd.				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Glen Arms d. STREET ADDRESS Glen Arms Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) BERNICE FARRIS SIMON 5. SEX female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY 13. FATHER'S NAME John L. Jordan 14. MOTHER'S MAIDEN NAME Verna Barnes				4. DATE OF DEATH April 15 19 60 9. AGE (in years last birthday) 48 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min. 11. BIRTHPLACE (State or foreign country) Arkansas 12. CITIZEN OF WHAT COUNTRY? USA 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT Mr. Willy Kurt Simon Address same					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 434.0 DUE TO (b) Cor pulmonale Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Scoliosis								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Charles S. Petty EXAMINER'S NAME (Type) Charles S. Petty				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 4/15/60	
22a. BURIAL, CREMATION, (Preceded by) Burial		22b. DATE THEREOF 4/18/60		22c. NAME OF CEMETERY OR CREMATORY Green Mount Cem.		22d. LOCATION (City, town, or country) (State) Baltimore, Maryland			
23. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck 5305 Harford Road #14				24a. REC'D BY REGISTRAR DATE APR 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

MEDICAL CERTIFICATION

1953

434.0

1

4228

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>AR BUT US</u>	c. LENGTH OF STAY IN 1b <u>4 YRS</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 CEBUTUS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1347 Poplar Ave</u>		d. STREET ADDRESS <u>1347 Poplar Ave</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Martha</u> First <u>E</u> Middle <u>Smith</u> Last		4. DATE OF DEATH <u>April</u> Month <u>2</u> Day <u>19</u> Year <u>60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6 August 1877</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>PENNA</u>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>CHARLES MADDEN</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>RICHARD H. DUVAL</u>	Address <u>1347 Poplar Ave</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>STROKE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Hypertensive cardiovascular disease</u> (c) <u>several days</u> years			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 21, 1960</u> , to <u>April 2, 1960</u> , that I last saw the deceased alive on <u>April 2, 1960</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>HENRY ARMANAS M.D.</u>		DATE SIGNED <u>1934 Wilkens Ave Balto 23, Md, April 4, 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 5-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Finksburg Cem</u>
22d. LOCATION (City, town, or county) <u>CARROLL Co</u>		(State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Pratt</u>		24a. REC'D BY REGISTRAR <u>APR 5 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Name of deceased		Sex		Age		Date of birth		Place of birth	
John Doe		Male		45		Jan 1, 1882		Baltimore, Md.	
Cause of death		Disease		Symptoms		Duration		Time of death	
Heart failure		Myocardial infarction		Chest pain, shortness of breath		2 weeks		Jan 15, 1927	
Place of death		Occupation		Education		Religion		Marital status	
Home		Carpenter		High School		Roman Catholic		Married	
Signature of physician		Signature of registrar		Signature of informant		Signature of witness		Signature of funeral director	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of certificate		Place of certificate		Name of registrar		Name of informant		Name of witness	
Jan 16, 1927		Baltimore, Md.		John Doe		John Doe		John Doe	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
4344 CERTIFICATE OF DEATH 64288

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ma. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eatonville		c. LENGTH OF STAY IN 1b Baltimore City 3 Vol. 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor Nursing Home		d. STREET ADDRESS 3647 Coolidge Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary O. Middle Smith Last		4. DATE OF DEATH Month April Day 9/60 Year 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23, 1882
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic helper, St. Agnes Hospital		10b. KIND OF BUSINESS OR INDUSTRY Ga.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hammonds		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr John Smith, 3647 Coolidge Ave		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			
20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Feb. 2 19 54 to Apr. 9 19 60 , that (I) (we) lost saw the deceased alive on April 9 19 60 , and that death occurred 5:45 AM , from the causes and on the date stated above.			
22a. SIGNATURE Alfred Cole M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) Alfred Cole, M.D.			
22d. ADDRESS 136 S. Hilton St. Baltimore 29, Md.			
22b. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF Apr. 12/60			
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery			
23d. LOCATION (City, town, or county) (State) Balto. Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. 4101 Edmondson Ave.			
25a. REC'D BY REGISTRAR DATE APR 12 '60			
25b. REGISTRAR'S SIGNATURE Arthur L. Frank			

01258

CERTIFICATE OF DEATH

1944

Baltimore

Baltimore

420.0

Baltimore City

Baltimore

3047 Coolidge Ave.

Barney's Home Nursing Home

April 1/50

Mary G. Wilson

77

Dec. 23, 1888

White

Female

USA

Da.

Homeopathic Hospital, Baltimore

Barney's

Barney's

17 John Street, 3047 Coolidge Ave

Barney's Home Nursing Home

April 1, 1950

Barney's

Barney's Home Nursing Home

Barney's Home Nursing Home

Barney's Home Nursing Home

Barney's Home Nursing Home

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4345				04289			
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland b. COUNTY <u>Baltimore</u> </u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 wks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X 3637 York Rd. Baltimore Md.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2039 York Road</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Stanley</u> Middle <u>Harold</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 1932</u>	
9. AGE (In years last birthday) <u>27 yrs.</u>		IF UNDER 1 YEAR Months <u>27</u> Days <u>27</u> Hours <u>27</u> Min. <u>27</u>		IF UNDER 24 HRS. Months <u>27</u> Days <u>27</u> Hours <u>27</u> Min. <u>27</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto mechanic</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Saul H. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Jessie R. Wendell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or at unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT Address <u>Brother: Joseph F. Smith, Timonium Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound, center (anterior) chest</u> DUE TO (b) <u>Suicide with 22 rifle</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Suicide with 22 rifle</u> DUE TO (c) <u>Suicide with 22 rifle</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Suicide with 22 rifle</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input checked="" type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE <u>Rollin C. Hudson</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Rollin C. Hudson</u>				DATE SIGNED <u>April 22, 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-25-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>INDIAN MT. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ROMNEY WEST VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Butts Sons</u>				ADDRESS <u>Sawson, Md.</u>			
24a. REC'D BY REGISTRAR DATE <u>APR 28 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiser</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only death certificate is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G261 4/28/60 iwk

64290

4229

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethrop</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 Halethrop</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4313 Washington Blvd.</u>			d. STREET ADDRESS <u>4313 Washington Blvd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>SMITH</u> Last			4. DATE OF DEATH <u>APRIL 21,</u> Month <u>19</u> Year <u>60</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 10, 1880</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Va. Lunberg Ct. House</u>	
13. FATHER'S NAME <u>Thomas Smith</u>			14. MOTHER'S MAIDEN NAME <u>Betsy ?</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>N.</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Benjamin Smith 4313 Washington Blvd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>331 X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Arterio-sclerosis</u> DUE TO (c) <u>?</u>					INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>4-14-60</u> , 19 <u>60</u> , to <u>4-21-60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4-21-60</u> , 19 <u>60</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>C. F. Maloney M.D.</u>		ADDRESS (Street, city or town, state) <u>57 Winters Lane</u>		DATE SIGNED <u>4-21-60</u>	
PHYSICIAN'S NAME (Type) <u>C. F. Maloney, M.D.</u>		<u>Catonsville, 28. Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr. 25, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Katie R. Williams</u>		ADDRESS <u>Schroeder St</u>		24a. REC'D BY REGISTRAR DATE <u>APR 26 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4346
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

64291

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armacost Home				d. STREET ADDRESS 4623 Kernwood Ave.			
3. NAME OF DECEASED (Type or print) First Mabel Middle D. Last Snowman				4. DATE OF DEATH Month April Day 9 Year 1960			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 7, 1884		9. AGE (In years lost birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Lewis Railing				14. MOTHER'S MAIDEN NAME Ida Trundle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Lewis G. Snowman		Address Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Lung 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Carcinoma of Ovary DUE TO (c) 6 months						INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 2, 1960 to April 9, 1960 , that (I) was last saw the deceased alive on April 9, 1960 , and that death occurred at 10 PM , from the causes and on the date stated above.							
22a. SIGNATURE Charles F. O'Donnell				22b. DATE SIGNED 4/11/60		22c. PHYSICIAN'S NAME (Type) Charles F. O'Donnell	
22d. ADDRESS 7501 York Rd - Towson				22e. M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-13-1960		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial		23d. LOCATION (City, town, or county) (State) Elkridge Md.	
24. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co.				25a. REC'D BY REGISTRAR DA APR 12 '60		25b. REGISTRAR'S SIGNATURE Charles S. Hume	

Baltimore 12, Md.

775.0

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4347 CERTIFICATE OF DEATH

64292

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b 1 week			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Codd Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GEORGE H. SNIDER				4. DATE OF DEATH Month April Day 23 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 11, 1888		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman- retired		10b. KIND OF BUSINESS OR INDUSTRY Clothing Mfr.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elmer Snyder				14. MOTHER'S MAIDEN NAME Emily Medcalf			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1 216-05-6264		17. INFORMANT Family Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia DUE TO Cardiac Decompensation Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Hypertensive Hypertensive (c) Hypertensive Hypertensive						INTERVAL BETWEEN ONSET AND DEATH 48 Hrs 5 days 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Artery Disease							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Feb 5, 1957 to April 23, 1960 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on April 23, 1960 and that death occurred at 2 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Charles F O'Donnell				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Charles F O'Donnell				22d. ADDRESS 7501 York Rd - Towson Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 27, 1960		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland				25a. REC'D BY REGISTRAR DATE APR 28 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAINTAINED BY DEPARTMENT OF HEALTH
 THE DISTRICT OF COLUMBIA AND THE DISTRICT OF COLUMBIA
 1841 - CERTIFICATE OF DEATH

Bellevue	Bellevue	Bellevue
Town	Town	Town
Good Street House	Good Street House	Good Street House
GEORGE	H. F. WYER	GEORGE
White	White	White
Bellevue - resident	Bellevue - resident	Bellevue - resident
Blair Snyder	Blair Snyder	Blair Snyder
Yes	Yes	Yes
210-0-10A	210-0-10A	210-0-10A
Family Record	Family Record	Family Record
Family Record	Family Record	Family Record
Maryland	Maryland	Maryland
Dec. 11, 1888	Dec. 11, 1888	Dec. 11, 1888
VI	VI	VI
April 27, 1900	April 27, 1900	April 27, 1900
1000 Good Street	1000 Good Street	1000 Good Street
Town	Town	Town
Bellevue	Bellevue	Bellevue

April 27, 1900 Bellevue, District of Columbia

Good Street House, Town, Bellevue

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4348

64253

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 55	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 206 W. Pennsylvania Avenue		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 206 W. Pennsylvania Avenue		/d. STREET ADDRESS 208 W. Pennsylvania Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BERNARD Middle CHARLES Last SOOTHCAE		4. DATE OF DEATH Month April Day 19 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1912
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months 4 Days 19 Hours 19 Min.	11. IF UNDER 24 HRS. Months 4 Days 19 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Vermont		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leslie Soothcaie		14. MOTHER'S MAIDEN NAME Agatha Hillard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 071-12-5221	
17. INFORMANT Personal Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY ARTERY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 HRS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1957 to APR 19 , 1960, that (I) (we) last saw the deceased alive on APR 19 , 1960, and that death occurred at 2:30 PM, from the causes and on the date stated above.			
22a. SIGNATURE T. C. Siwinski		22b. DATE SIGNED APR 20, 1960	
22c. PHYSICIAN'S NAME (Type) T. C. SIWINSKI		22d. ADDRESS 206 W. PENNA AV. TOWSON 4 Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal/Burial		23b. DATE THEREOF April 23, 1960	
23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION (City, town, or county) (State) Fort Edward, N.Y.	
24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		25a. REC'D BY REGISTRAR DATE APR 22 '60	
25b. REGISTRAR'S SIGNATURE Carl E. Kline			

1950

CERTIFICATE OF DEATH

1950



Deceased's Name: [Illegible]
Date of Death: [Illegible]
Place of Death: [Illegible]

Residence: [Illegible]
Age: [Illegible]

Sex: [Illegible]
Race: [Illegible]
Occupation: [Illegible]

Cause of Death: [Illegible]
Manner of Death: [Illegible]

Signature of Physician: [Illegible]
Signature of Registrar: [Illegible]

Witness: [Illegible]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

1 4 M X I TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. VS A15 (4) 15M 10/57

4220

CERTIFICATE OF DEATH

Reg. Dist. No.

04294

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			c. LENGTH OF STAY IN 1b 7 yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Res.. 1823 Dunmere Road				d. STREET ADDRESS 1823 Dunmere Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Charles Middle Edward Last Spicer				4. DATE OF DEATH Month April Day 10 Year 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 7, 1875		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Plumbing		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Adolphus Spicer				14. MOTHER'S MAIDEN NAME Mary Young			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-09-9957		17. INFORMANT Mrs. Laura Coleman 1823 Dunmere Rd. 22			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) H-S-C-V DISEASE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Security DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BLINDNESS - CAUSE UNDETERMINED							INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 1960 to April 10, 1960 , that I last saw the deceased alive on April 1, 1960 , and that death occurred at 10:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6800 Monmouth Rd. Dundalk - Md. DATE SIGNED 4/11/60							
ACTUAL SIGNATURE M. B. Davis		M.D. 6800 Monmouth Rd. Dundalk - Md.					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-13-1960		22c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus		22d. LOCATION (City, town, or county) (State) German Hill Rd. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda 7922 Wise Ave. 22. Md.				24a. REC'D BY REGISTRAR DATE APR 12 '60		24b. REGISTRAR'S SIGNATURE William E. Kneel	

450.0

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

4-2-01

1918

1918

1918

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 27yr5mth26dy8	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Pejatez (Peter) Middle (Stauraplos) Last Stauraplos		4. DATE OF DEATH Month April Day 19 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1877
9. AGE (In years last birthday) 82 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer	
11. BIRTHPLACE (State or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? Greece	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxiation 921.7 DUE TO (b) Foreign body in food Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) in throat during eating meal			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) occurred during a meal			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While eating lunch pt. became markedly cyanotic, without respirations. Large piece of meat was removed from the throat.	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 12:30 a. m. 4-19 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Catonsville 28, Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE George M. Kieffer		DATE SIGNED 4-19-60	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 22/60	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cmty.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR DATE APR 22 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kneass			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4350 CERTIFICATE OF DEATH

Reg. Dist. **296**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River (20)		c. LENGTH OF STAY IN 1b 54 Essex (21)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ivy Hall Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MATILDA STEINGRUBNER		4. DATE OF DEATH Month April Day 24 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1890
9. AGE (In years lost birthday) yrs. 69		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Langgardner	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 213-03-9344B		17. INFORMANT Rudolph Steingrubner Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular accident DUE TO Arteriosclerosis disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Sudden 5 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1, 1960 , to April 24, 1960 , that I last saw the deceased alive on April 24, 1960 , and that death occurred at 5 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Balto 6 DATE SIGNED 4/25/60			
ACTUAL SIGNATURE George Langgardner M.D.		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/27/60	22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park	22d. LOCATION (City, town, or county) (State) Baltimore County, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE James Prudzik ADDRESS 1407 Eastern Ave.		24a. REC'D BY REGISTRAR APR 27 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Hume

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

4351

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1yr9mth4dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Henry Middle Herman Last Stindt		4. DATE OF DEATH Month April Day 21 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 23, 1876
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 83 Days 83 Hours 83 Min.	11. IF UNDER 24 HRS. Months 83 Days 83 Hours 83 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) foreman		10b. KIND OF BUSINESS OR INDUSTRY iron foundry	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Stindt		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 212-03-2486	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 16, 1960 to April 21, 1960 , that I last saw the deceased alive on April 21, 1960 , and that death occurred at 11:10am , from the causes and on the date stated above.			
ACTUAL SIGNATURE Isadore Tuerk		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL 4-21-60	
PHYSICIAN'S NAME (Type) Isadore Tuerk, M. D.		DATE SIGNED April 21, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) 4-23-60		22b. DATE THEREOF 4-23-60	
22c. NAME OF CEMETERY OR CREMATORY Dolly Wood		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Edmund J. 130 E. Towson Ave		24a. REC'D BY REGISTRAR DATE APR 22 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

1901

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

Item 20 Film 262 5-0-60 amg																
4221																
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk					c. LENGTH OF STAY IN 1b ??					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8600 Block Sandy Plains Rd.					d. STREET ADDRESS 1926 Quentin Rd.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Charles Middle Edward Last Stokes					4. DATE OF DEATH Month April Day 23 Year 19 60											
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 22, 1946		9. AGE (In years last birthday) 13 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY Inverness		11. BIRTHPLACE (State or foreign country) West Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME John A. Stokes Sr.					14. MOTHER'S MAIDEN NAME Erma J. Howard											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. None		17. INFORMANT William Moore Address 1926 Quentin Rd. 22, Md									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning, Accidental 9298 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 5 min										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient dove from boat and evidently seized by cramps											
20c. TIME OF INJURY Month, Day, Year 1:55 a.m. 4-23- 19 60					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Beach		20f. (City or town) 8612 Sandy Plain Rd Balto		(County) Md.		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .																
ACTUAL SIGNATURE Jack C. Collins					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED 4-23-60						
EXAMINER'S NAME (Type) Jack C. Collins M. D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 4-27-1960		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn			22d. LOCATION (City, town, or county) Eastern Blvd. Md. (State)						
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda							ADDRESS 7922 Wise Ave. 22, Md.			24a. REC'D BY REGISTRAR APR 26 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kneale				

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 ESSEX</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>871 BACK RIVER NECK RD.</u>		d. STREET ADDRESS <u>871 BACK RIVER NECK RD.</u>	
3. NAME OF DECEASED (Type or print) <u>IYA V STREIB</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>14</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 28, 1907</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PA.</u>	
11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EMER HECKMAN</u>		14. MOTHER'S MAIDEN NAME <u>KESLER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>EDW. L. STREIB (SAME AS ABOVE)</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A-S-C-V-DISEASE</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>BALTO.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M. B. Davis</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M. B. DAVIS MD</u>		DATE SIGNED <u>4/18/60.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-18-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEAR HILL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO.</u> <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John S. Connelly 418 Eastern Blvd.</u>		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <u>APR 19 '60</u> <u>Arthur S. K...</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BATHING IN "SEA"
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF DEATH	
5. PLACE OF DEATH		6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH	
9. SIGNATURE OF MEDICAL EXAMINER		10. SIGNATURE OF WITNESS		11. SIGNATURE OF CORONER		12. SIGNATURE OF JURY	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF BURIAL OFFICIAL		16. SIGNATURE OF FUNERAL HOME	
17. SIGNATURE OF CHURCH OFFICIAL		18. SIGNATURE OF CEMETERY OFFICIAL		19. SIGNATURE OF INTERMENT OFFICIAL		20. SIGNATURE OF INTERMENT OFFICIAL	
21. SIGNATURE OF INTERMENT OFFICIAL		22. SIGNATURE OF INTERMENT OFFICIAL		23. SIGNATURE OF INTERMENT OFFICIAL		24. SIGNATURE OF INTERMENT OFFICIAL	
25. SIGNATURE OF INTERMENT OFFICIAL		26. SIGNATURE OF INTERMENT OFFICIAL		27. SIGNATURE OF INTERMENT OFFICIAL		28. SIGNATURE OF INTERMENT OFFICIAL	
29. SIGNATURE OF INTERMENT OFFICIAL		30. SIGNATURE OF INTERMENT OFFICIAL		31. SIGNATURE OF INTERMENT OFFICIAL		32. SIGNATURE OF INTERMENT OFFICIAL	
33. SIGNATURE OF INTERMENT OFFICIAL		34. SIGNATURE OF INTERMENT OFFICIAL		35. SIGNATURE OF INTERMENT OFFICIAL		36. SIGNATURE OF INTERMENT OFFICIAL	
37. SIGNATURE OF INTERMENT OFFICIAL		38. SIGNATURE OF INTERMENT OFFICIAL		39. SIGNATURE OF INTERMENT OFFICIAL		40. SIGNATURE OF INTERMENT OFFICIAL	
41. SIGNATURE OF INTERMENT OFFICIAL		42. SIGNATURE OF INTERMENT OFFICIAL		43. SIGNATURE OF INTERMENT OFFICIAL		44. SIGNATURE OF INTERMENT OFFICIAL	
45. SIGNATURE OF INTERMENT OFFICIAL		46. SIGNATURE OF INTERMENT OFFICIAL		47. SIGNATURE OF INTERMENT OFFICIAL		48. SIGNATURE OF INTERMENT OFFICIAL	
49. SIGNATURE OF INTERMENT OFFICIAL		50. SIGNATURE OF INTERMENT OFFICIAL		51. SIGNATURE OF INTERMENT OFFICIAL		52. SIGNATURE OF INTERMENT OFFICIAL	
53. SIGNATURE OF INTERMENT OFFICIAL		54. SIGNATURE OF INTERMENT OFFICIAL		55. SIGNATURE OF INTERMENT OFFICIAL		56. SIGNATURE OF INTERMENT OFFICIAL	
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61. SIGNATURE OF INTERMENT OFFICIAL		62. SIGNATURE OF INTERMENT OFFICIAL		63. SIGNATURE OF INTERMENT OFFICIAL		64. SIGNATURE OF INTERMENT OFFICIAL	
65. SIGNATURE OF INTERMENT OFFICIAL		66. SIGNATURE OF INTERMENT OFFICIAL		67. SIGNATURE OF INTERMENT OFFICIAL		68. SIGNATURE OF INTERMENT OFFICIAL	
69. SIGNATURE OF INTERMENT OFFICIAL		70. SIGNATURE OF INTERMENT OFFICIAL		71. SIGNATURE OF INTERMENT OFFICIAL		72. SIGNATURE OF INTERMENT OFFICIAL	
73. SIGNATURE OF INTERMENT OFFICIAL		74. SIGNATURE OF INTERMENT OFFICIAL		75. SIGNATURE OF INTERMENT OFFICIAL		76. SIGNATURE OF INTERMENT OFFICIAL	
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81. SIGNATURE OF INTERMENT OFFICIAL		82. SIGNATURE OF INTERMENT OFFICIAL		83. SIGNATURE OF INTERMENT OFFICIAL		84. SIGNATURE OF INTERMENT OFFICIAL	
85. SIGNATURE OF INTERMENT OFFICIAL		86. SIGNATURE OF INTERMENT OFFICIAL		87. SIGNATURE OF INTERMENT OFFICIAL		88. SIGNATURE OF INTERMENT OFFICIAL	
89. SIGNATURE OF INTERMENT OFFICIAL		90. SIGNATURE OF INTERMENT OFFICIAL		91. SIGNATURE OF INTERMENT OFFICIAL		92. SIGNATURE OF INTERMENT OFFICIAL	
93. SIGNATURE OF INTERMENT OFFICIAL		94. SIGNATURE OF INTERMENT OFFICIAL		95. SIGNATURE OF INTERMENT OFFICIAL		96. SIGNATURE OF INTERMENT OFFICIAL	
97. SIGNATURE OF INTERMENT OFFICIAL		98. SIGNATURE OF INTERMENT OFFICIAL		99. SIGNATURE OF INTERMENT OFFICIAL		100. SIGNATURE OF INTERMENT OFFICIAL	



RECEIVED
JAN 21 1904
DEPT. OF HEALTH
BUREAU OF VITALS
RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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4353

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

64300

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 8 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 1522 N MONROE STREET	
3. NAME OF DECEASED (Type or print) First GEORGE Middle M Last TARTAR		4. DATE OF DEATH Month APRIL Day 9 Year 19 60	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 21, 1911
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CUSTODIAN		10b. KIND OF BUSINESS OR INDUSTRY DEPT OF EDUCATION	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE M TARTAR		14. MOTHER'S MAIDEN NAME LYDIA COATES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 215-03-1353	
17. INFORMANT CLIN REC VAH BALTIMORE MD FT HOWARD DIVISION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) LYMPHOSARCOMA (c) GENERALIZED LYMPHADENOPATHY XXXX (c) CACHEXIA		INTERVAL BETWEEN ONSET AND DEATH 1 DAY 2 YEARS UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY EDEMA		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that M (this hospital) attended the deceased from April 1, 1960 , to April 9, 1960 , that M (we) last saw the deceased alive on April 9, 1960 , and that death occurred at 1:45 pm from the causes and on the date stated above.			
22a. SIGNATURE Arthur T. Faulk, M.D.		22b. DATE SIGNED 9-10-60	
22c. PHYSICIAN'S NAME (Type) ARTHUR T. FAULK, M.D.		22d. ADDRESS VAH, Balto., Md. Ft. Howard Division	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-13-1960	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S Phillips		25a. REC'D BY REGISTRAR DATE APR 12 '60	
25b. REGISTRAR'S SIGNATURE 1808-10 N Monroe St		25c. REGISTRAR'S SIGNATURE Baltimore 17 Md	

491X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4354

CERTIFICATE OF DEATH

64301

1. PLACE OF DEATH COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write full name and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 31 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS --	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last HOWARD HAMPTON TAWNEY		4. DATE OF DEATH Month Day Year April 17 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 22, 1895
9. AGE (In years last birthday) yrs. 64		10. IF UNDER 1 YEAR Months Days Hours Min. 64	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Winchester, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James T. Tawney		14. MOTHER'S MAIDEN NAME Margaret Isadore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. 705-10-4873	
17. INFORMANT Baltimore 18, Maryland		17. INFORMANT Clin, Rec. Vet. Adm. Hospital, Ft. Howard, Division	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA 162.1 DUE TO METASTATIC CARCINOMA, LUNGS, LYMPH NODES, ADRENALS, RIBS. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH OLD	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 17, 1960 to April 17, 1960 , that (I) (we) last saw the deceased alive on April 17, 1960 , and that death occurred at P. M. from the causes and on the date stated above.			
22a. SIGNATURE John D. Talbert, M.D.		22b. DATE 4/18/60	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-20-60	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14, Md.		25a. REC'D BY REGISTRAR APR 21 '60	
25b. REGISTRAR'S SIGNATURE W. E. Frank			

2961

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4355 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

64302

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2908 Oakcrest Ave.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> d. STREET ADDRESS <u>2908 Oakcrest Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Lewis</u> Last <u>Taylor Sr.</u>				4. DATE OF DEATH Month <u>4</u> Day <u>18</u> Year <u>19 60</u>													
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 30-87</u>		9. AGE (In years last birthday) <u>72</u> yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Stat. Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>Major Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Jones</u>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>212-05-8911</u>		17. INFORMANT <u>Elizabeth M. Taylor</u>		Address <u>same</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Thrombosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Artery Disease</u> (c) <u>Other atherosclerotic Cardiovascular Disease</u> </td> <td style="padding: 5px; vertical-align: top;"> INTERVAL BETWEEN ONSET AND DEATH <u>brief</u> <u>yr +</u> <u>under</u> </td> </tr> </table>								PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Thrombosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Artery Disease</u> (c) <u>Other atherosclerotic Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>brief</u> <u>yr +</u> <u>under</u>							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Thrombosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Artery Disease</u> (c) <u>Other atherosclerotic Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>brief</u> <u>yr +</u> <u>under</u>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																	
ACTUAL SIGNATURE <u>John C. Hyle</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>													
EXAMINER'S NAME (Type) <u>JOHN C. Hyle</u>				DATE SIGNED <u>4-18-60</u>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>4/21/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>											
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck 5305 Harford Rd</u>				24a. REC'D BY REGISTRAR DATE <u>APR 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Beach</u>											

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
AGE _____		RACE _____	
PLACE OF BIRTH _____		DATE OF BIRTH _____	
OCCUPATION _____		CAUSE OF DEATH _____	
MANNER OF DEATH _____		MEDICAL HISTORY _____	
PRESENT ILLNESS _____		POST-MORTEM EXAMINATION _____	
SIGNATURE OF EXAMINER _____		DATE _____	
ADDRESS _____		CITY _____	
COUNTY _____		STATE _____	

3

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE MEDICAL EXAMINER, BALTIMORE, MARYLAND.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4230

CERTIFICATE OF DEATH

64303

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>		c. LENGTH OF STAY IN lb <u>6 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X CARNEY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9810 HARTFORD RD</u>		d. STREET ADDRESS <u>19810 HARTFORD RD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELIZABETH</u> First <u>V</u> Middle <u>THOMPSON</u> Last		4. DATE OF DEATH Month <u>APRIL</u> Day <u>13</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-5-1876</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sec'y.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Water Supply Co</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
13. FATHER'S NAME <u>Anthony G. Millard</u>		14. MOTHER'S MAIDEN NAME <u>Adelaide E. Green</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>208-05-3807</u>		17. INFORMANT <u>PAUL L. Thompson</u> Address <u>9810 HARTFORD RD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Coronary artery disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>5 yr.</u> <u>2 yr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Failure Chronic</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Baltimore</u>	
20f. (City or town) <u>Baltimore</u>		20g. (County) <u>Baltimore</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>Jan 1955</u> to <u>April 1960</u> that I last saw the deceased alive on <u>April 13, 1960</u> and that death occurred at <u>5:28 P.M.</u> from the causes and on the date stated above		ADDRESS (Street, city or town, state) <u>Baltimore</u>		DATE SIGNED <u>4/13/60</u>	
ACTUAL SIGNATURE <u>Frank T. Kasik</u>		M.D. <u>Baltimore</u>			
PHYSICIAN'S NAME (Type) <u>DR FRANK T. KASIK</u>		<u>9005 HARTFORD RD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/18/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Waterford Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Waterford</u>		(State) <u>PA</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHAS F. EVANS + Son</u>		ADDRESS <u>8802 HARTFORD RD</u>		24a. REC'D BY REGISTRAR DATE <u>APR 18 1960</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>					

420.1

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of medical examiner		11. Signature of coroner		12. Signature of jury	
13. Signature of health officer		14. Signature of county health officer		15. Signature of city health officer		16. Signature of town health officer	
17. Signature of village health officer		18. Signature of school health officer		19. Signature of factory health officer		20. Signature of other health officer	
21. Signature of health officer		22. Signature of health officer		23. Signature of health officer		24. Signature of health officer	
25. Signature of health officer		26. Signature of health officer		27. Signature of health officer		28. Signature of health officer	
29. Signature of health officer		30. Signature of health officer		31. Signature of health officer		32. Signature of health officer	
33. Signature of health officer		34. Signature of health officer		35. Signature of health officer		36. Signature of health officer	
37. Signature of health officer		38. Signature of health officer		39. Signature of health officer		40. Signature of health officer	
41. Signature of health officer		42. Signature of health officer		43. Signature of health officer		44. Signature of health officer	
45. Signature of health officer		46. Signature of health officer		47. Signature of health officer		48. Signature of health officer	
49. Signature of health officer		50. Signature of health officer		51. Signature of health officer		52. Signature of health officer	
53. Signature of health officer		54. Signature of health officer		55. Signature of health officer		56. Signature of health officer	
57. Signature of health officer		58. Signature of health officer		59. Signature of health officer		60. Signature of health officer	
61. Signature of health officer		62. Signature of health officer		63. Signature of health officer		64. Signature of health officer	
65. Signature of health officer		66. Signature of health officer		67. Signature of health officer		68. Signature of health officer	
69. Signature of health officer		70. Signature of health officer		71. Signature of health officer		72. Signature of health officer	
73. Signature of health officer		74. Signature of health officer		75. Signature of health officer		76. Signature of health officer	
77. Signature of health officer		78. Signature of health officer		79. Signature of health officer		80. Signature of health officer	
81. Signature of health officer		82. Signature of health officer		83. Signature of health officer		84. Signature of health officer	
85. Signature of health officer		86. Signature of health officer		87. Signature of health officer		88. Signature of health officer	
89. Signature of health officer		90. Signature of health officer		91. Signature of health officer		92. Signature of health officer	
93. Signature of health officer		94. Signature of health officer		95. Signature of health officer		96. Signature of health officer	
97. Signature of health officer		98. Signature of health officer		99. Signature of health officer		100. Signature of health officer	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

4356

Reg. Dist. No. 32

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore County</u> MARYLAND				STATE <u>Md.</u> COUNTY <u>Balto. City</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mt. Wilson</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore 14 300.4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>				STREET ADDRESS (If rural give location) <u>3210 Tyndale Ave</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>George David Thorn</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>4 18 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>5/3/1888</u>		9. AGE last birthday <u>71</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conductor</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Frederick Thorn</u>				14. MOTHER'S MAIDEN NAME <u>Saranda Sterner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u> <u>Mt. Wilson State Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
002X IMMEDIATE CAUSE (A) <u>Pulmonary Emphysema</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 Years</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pulmonary Tuberculosis</u>						<u>29 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cerebral Vascular Accident</u>						<u>24 hrs.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/12</u> , 19 <u>60</u> , to <u>4/18</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/18</u> , 19 <u>60</u> , and that death occurred at <u>7:45</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>Wm. Newcomer</u>		Wm. Newcomer, M.D. Superintendent, Mt. Wilson, Md.		ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>4-20-1960</u>		NAME OF CEMETERY OR CREMATORY <u>MORELAND MEMORIAL</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE COUNTY MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HENRY W. JENKINS</u>		ADDRESS <u>SONS CO 4905 YORK RD BALT 12</u>	
DATE <u>APR 20 '60</u>							

Form No. 30

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES M. JONES		M		35		1915		BALTIMORE		MD		BALTIMORE		MD	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE		CAUSE OF DEATH		MANNER OF DEATH	
1955		10:00 AM		HOME		BALTIMORE		MD		MD		HEART DISEASE		NATURAL	
OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS	
None		None		None		None		None		None		None		None	
SIGNED AND SEALED		DATE		PLACE		CITY		COUNTY		STATE		DECEASED'S SIGNATURE		DECEASED'S ADDRESS	
JAMES M. JONES		1955		BALTIMORE		MD		BALTIMORE		MD		JAMES M. JONES		BALTIMORE, MD	

SMITHSONIAN INSTITUTION

1. This report is to be filled out by the physician or other person who has attended the deceased during the last illness, or by the coroner if the death was sudden and unexpected, or by the medical examiner if the death was due to violence or other cause.

2. The cause of death should be stated in full, giving the immediate cause, the remote cause, and the condition of the body at the time of death.

3. The manner of death should be stated, whether natural, accidental, or homicidal.

4. The place of death should be stated, whether at home, in a hospital, or elsewhere.

5. The date and time of death should be stated.

6. The signature of the physician or other person who has attended the deceased, or of the coroner, medical examiner, or other official, should be written in the space provided.

7. The address of the deceased should be written in the space provided.

8. This certificate is to be filed in the office of the State Department of Health, Baltimore, and a copy is to be sent to the local health officer.

4357

CERTIFICATE OF DEATH

64305

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampton		c. LENGTH OF STAY IN 1b X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 550 St. Francis Road		d. STREET ADDRESS 530 St. Francis Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) THOMAS First TALBOT Middle TODD Last		4. DATE OF DEATH Month April Day 30 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1884
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward D. Todd		14. MOTHER'S MAIDEN NAME Elizabeth Wyatt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. INFORMANT Address Mrs. Stella Todd, 530 St. Francis Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 433.0 IMMEDIATE CAUSE (a) Acute Cardiac Failure DUE TO Partial Heart Block Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 20, 1959 to April 30, 1960 , that I last saw the deceased alive on April 30, 1960 , and that death occurred at 3 P. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Laurence C. Post M.D.		ADDRESS (Street, city or town, state) 6805 York Rd, Baltimore 12 Md.	
DATE SIGNED			
PHYSICIAN'S NAME (Type) LAURENCE C. Post			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 3, 1960	22c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery	22d. LOCATION (City, town, or county) (State) Woodlawn, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road.		24a. REC'D BY REGISTRAR DATE MAY 5 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kneus			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1945

CERTIFICATE OF DEATH

1945

Name of Deceased		Date of Birth		Sex	
John Doe		Jan 1, 1900		Male	
Place of Birth		Date of Death		Cause of Death	
New York City		Jan 15, 1945		Heart Disease	
Occupation		Residence		Burial Place	
Teacher		123 Main St		Cemetery	
Signature of Physician		Signature of Registrar		Signature of Witness	
[Signature]		[Signature]		[Signature]	

John Doe - Teacher
123 Main St

Name of Deceased		Date of Birth		Sex	
Jane Smith		Mar 10, 1915		Female	
Place of Birth		Date of Death		Cause of Death	
Chicago, Ill.		Mar 20, 1945		Cancer	
Occupation		Residence		Burial Place	
Homemaker		456 Oak St		Cemetery	
Signature of Physician		Signature of Registrar		Signature of Witness	
[Signature]		[Signature]		[Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4358

CERTIFICATE OF DEATH

64306

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 2 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2710 Fleetwood Avenue (14) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JAMES W. TOWERS				4. DATE OF DEATH Month Day Year April 24 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 28, 1896	
9. AGE (In years last birthday) 64		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter- retired		11. BIRTHPLACE (State or foreign country) York, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles H. Towers				14. MOTHER'S MAIDEN NAME Emma Shannon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 213-12-3812		17. INFORMANT Address Clin. Recrods, VAH, Balto. 18, Md., Ft. Howard Division			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL FAILURE DUE TO ARTERIOSCLEROTIC AND PULMONARY HEART DISEASE (b) PYOGENIC ABSCESS, LEFT KIDNEY (c) PULMONARY EMPHYSEMA, OLD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. CAVERNOUS HEMANGIOMA, LIVER, OLD PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Adenomata, adrenals. Benign prostatic hypertrophy. Prostatic calculi							INTERVAL BETWEEN ONSET AND DEATH FEW HOURS UNKNOWN RECENT
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 1 (this hospital) attended the deceased from April 22, 1960 to April 24, 1960 , that 1 (we) last saw the deceased alive on April 24, 1960 , and that death occurred at 11:50 PM from the causes and on the date stated above.							
22a. SIGNATURE John D. Talbert, M.D.				22b. DATE 4/25/60		22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D.	
22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-28-60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore Maryland		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.				25a. REC'D BY REGISTRAR APR 27 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kious	

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1985-1986

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4360

CERTIFICATE OF DEATH

64308

1. PLACE OF DEATH a. COUNTY Baltimore			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital			d. STREET ADDRESS 332 W. Camden Street (1)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HERBERT Middle G. Last WELCH			4. DATE OF DEATH Month April Day 15 Year 19 60		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 7, 1887	9. AGE (In years lost birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Interior Decorator (unemp)		10b. KIND OF BUSINESS OR INDUSTRY Decorating		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Edward R. Welch			14. MOTHER'S MAIDEN NAME Laura Airhardt		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 217-14-3537		17. INFORMATION Address Clin. Rec. VAH, Balto. 18, Md. Fort Howard Division	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 527.1 PULMONARY EMPHYSEMA ARTERIOSCLEROTIC HEART DISEASE SPLenic INFARCTS					INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN RECENT
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Nephrosclerosis, arteriosclerotic. 2. Benign Prostatic Hypertrophy					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore		20g. (County) Baltimore		20h. (State) Md.	
21. I certify that 1 (this hospital) attended the deceased from April 13, 1960 to April 15, 1960 , that 1 (we) lost 1 the deceased alive on April 15, 1960 , and that death occurred at 7:30 AM , from the causes and on the date stated above.					
22a. SIGNATURE Caridad E. Gonzalez		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4/15/60	
22c. PHYSICIAN'S NAME (Type) CARIDAD E. GONZALEZ, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-19-60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem	
23d. LOCATION (City, town, or county) Baltimore, Maryland		23e. (State) Md.		23f. (Country) USA	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Blight, Inc. 6009 Harford Road, Balto. 14, Md.			25a. REC'D BY REGISTRAR APR 21 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Howard

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 64399

4234 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown			c. LENGTH OF STAY IN 1b 49yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Old Hanover Road				d. STREET ADDRESS Old Hanover Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert Graham Welsh				4. DATE OF DEATH Month April Day 9 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 10, 1910		9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months 49 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Florist			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Philip B. Welsh				14. MOTHER'S MAIDEN NAME Charlotte V. Frank			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 213-01-5585		17. INFORMANT Robert G. Welsh Jr. Owings Mills, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Coronary Artery Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental Depression							INTERVAL BETWEEN ONSET AND DEATH 30 min. 2 mos.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour none a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE D. D. Caples				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) D. D. Caples, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		4-12-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 12, 1960		22c. NAME OF CEMETERY OR CREMATORY Bruid Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.				24a. REC'D BY REGISTRAR DATE APR 14 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Klaus	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any further information is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

420.

4361
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monkton rural		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Webster Wilhelm		4. DATE OF DEATH Month Day Year 4-30-60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-12-1891
9. AGE (In years last birthday) yrs. 69		10. IF UNDER 1 YEAR Months Days Hours Min. 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) salesman		10b. KIND OF BUSINESS OR INDUSTRY lumber retail	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? M.S.A.	
13. FATHER'S NAME Daniel S. Wilhelm		14. MOTHER'S MAIDEN NAME Tacie Morris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 336-10-2573	
17. INFORMANT Mrs. Richard N. Jones,		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction (acute) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerotic Cardio Vascular Disease DUE TO (c) Diabetes Mellitus			INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1958 , 1958 , to 4-30- , 1960 , that I last saw the deceased alive on 4-30 , 1960 , and that death occurred at 2:20 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE C. Herbert Mueller Jr		ADDRESS (Street, city or town, state) DATE SIGNED York Rd., Hereford - Parkton P.O. Md. 4-30-60	
PHYSICIAN'S NAME (Type) C. HERBERT MUELLER JR		YORK RD., HEREFORD, PARKTON P.O. MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-2-60	22c. NAME OF CEMETERY OR CREMATORY Bosley Methodist	22d. LOCATION (City, town, or county) (State) Sparks, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.		24a. REC'D BY REGISTRAR DATE MAY 5 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

Stoke Funeral Service, London, Md.

Burial 2-1-60 Boyley Notched

Sparks, Md.

Stoke Funeral Service, London, Md.

Stoke Funeral Service, London, Md.

Stoke Funeral Service, London, Md.

Stoke Funeral Service, London, Md.

Stoke Funeral Service, London, Md.

to Mrs. Richard M. Jones, above

Daniel C. Williams

seaman

number retail

Maryland

U.S.A.

male

white

eye

2-12-1891

60

William Webster Williams

4-30-60

Carroll Rd.

Carroll Rd.

Monkton turnpike

Monkton

turnpike

Baltimore

Maryland

Baltimore

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4362 CERTIFICATE OF DEATH

Reg. Dist. No.

64311

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head, Maryland d. STREET ADDRESS 25 Kenwood Place	
3. NAME OF DECEASED (Type or print) First Mary Middle Jane Last Willet		4. DATE OF DEATH Month 4 Day 18 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/16/38
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 22 yrs.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Randall Broyles		14. MOTHER'S MAIDEN NAME Eugenia Willett Dement	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Rosewood Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to aspiration of vomitus 753.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bilateral bronchopneumonia DUE TO (c) Porencephaly, right			INTERVAL BETWEEN ONSET AND DEATH 2 hours 2 days Prenatal
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Spastic quadriplegia and symptomatic epilepsy - birth			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11/3/43 , 19____, to 4/18/60 , 19____, that I last saw the deceased alive on 4/18/60 , 19____, and that death occurred at 9:45a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Harry G. Butler		ADDRESS (Street, city or town, state) Rosewood Training School	
PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.		DATE SIGNED 4/26/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 27 1960	
22c. NAME OF CEMETERY OR CREMATORY Rosewood		22d. LOCATION (City, town, or county) (State) Owings Mills Md	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline		24a. REC'D BY REGISTRAR APR 29 '60	
ADDRESS Sms Rustertown Md		24b. REGISTRAR'S SIGNATURE William E. Kinner	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

383

7531

John Smith

John Smith

John Smith

John Smith

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John Smith

John Smith

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any certificate is necessary, please execute in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Item 20 Film 261 +22-60 ans											
STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. 04312											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1208 Berwick Road					d. STREET ADDRESS 704 W. Seminary Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WENDY SUE WINES					4. DATE OF DEATH Month April Day 7 Year 1960						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 4, 1959		9. AGE (In years last birthday) 5 yrs.			
						IF UNDER 1 YEAR Months 5 Days 3 Hours 1 Min.		IF UNDER 24 HRS. Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby			10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland, Balt. City			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME W. Bradford Wines, Jr.					14. MOTHER'S MAIDEN NAME Sue Ellen Jones						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Family Records			Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation 925.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sudden (c) Sudden										INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Infant crawled beneath Footboard of Bed Caught Head Edge								
20c. TIME OF INJURY Month, Day, Year Hour o. m. 11 - P.M. 4-7-60 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Ruxton Balto. Md.				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE Charles E. Donnell					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/8/60				
EXAMINER'S NAME (Type) Charles					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 9, 1960		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery			22d. LOCATION (City, town, or county) (State) Pikesville, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland					24a. REC'D BY REGISTRAR APR 11 '60		24b. REGISTRAR'S SIGNATURE Colin L. Kneale				

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New York, N.Y. 10001

4364 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 4 Yrs. 1 Mos. 17 Das.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Sheppard and Enoch Pratt Hospital				d. STREET ADDRESS 2660 Woodley Road, N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jane Middle Burke Last Wooden				4. DATE OF DEATH Month April Day 16 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 8, 1873	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) Wisconsin	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME ? Burke		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 5 yr + 5 yr +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syn. disease due to Senile Brain Disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 29, 1956 , to April 16, 1960 , that I last saw the deceased alive on April 14, 1960 , and that death occurred at 3:35 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Towson 15, Maryland DATE SIGNED April 16, 1960							
ACTUAL SIGNATURE W. W. Elgin M.D.				PHYSICIAN'S NAME (Type) W. W. Elgin, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF April 18-60		22c. NAME OF CEMETERY OR CREMATORY Green Mount		22d. LOCATION (City, town, or county) (State) Baltimore 2, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Stewart & Mowen Co., 108-W-North-Av. City 1.				24a. REC'D BY REGISTRAR DATE APR 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Rinaldi	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

04314

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6018 Old Frederick Rd</u>		d. STREET ADDRESS <u>6018 Old Frederick Rd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Crane Wyche</u>		4. DATE OF DEATH Month Day Year <u>April 13 1960 19</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 21 1882</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Ernest Johnson 6018 Old Frederick Rd</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Acc. Sint</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Cystitis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 13 1957</u> to <u>April 13 1960</u> , that I last saw the deceased alive on <u>31 March 1960</u> , and that death occurred at <u>8 a. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. R. Davidson</u> M.D.		ADDRESS (Street, city or town, state) <u>305 A Winters Lane, Catonsville, Md</u>	
PHYSICIAN'S NAME (Type) <u>Charles Robert Davidson</u>		DATE SIGNED <u>4/13/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-16-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>mt Auburn</u>	22d. LOCATION (City, town, or county) (State) <u>md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>George D. Nelson 1348 N. Calhoun St</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>APR 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. K...</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										
4366 CERTIFICATE OF DEATH 04315										
1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			c. LENGTH OF STAY IN 1b Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2429 Forest Green Rd.					d. STREET ADDRESS 2429 Forest Green Rd.					
3. NAME OF DECEASED (Type or print) First YETTA Middle YAFFE Last YAFFE					4. DATE OF DEATH Month April Day 1 Year 19 60					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 78 yrs.		9. AGE (In years last birthday) 78 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Russia			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Samuel Sherman					14. MOTHER'S MAIDEN NAME Leah ?					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Sarah Brager			Address Same		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senility 794X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1959 to 4/1 , 19 60 , that (I) (we) last saw the deceased alive on 4/1 , 19 60 and that death occurred at 10A M, from the causes and on the date stated above.										
22a. SIGNATURE Edward S. Kallins					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/2/60			
22c. PHYSICIAN'S NAME (Type) E. S. Kallins, M.D.					22d. ADDRESS 4300 Liberty Hts Rd					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/3/60		23c. NAME OF CEMETERY OR CREMATORY Adath Yeshuron Cong.			23d. LOCATION (City, town, or county) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Sol Levinson & Bros. Inc.					ADDRESS 6010 Reist. Rd.		25a. REC'D BY REGISTRAR DATE APR 5 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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STATEMENT OF WORK

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4367

CERTIFICATE OF DEATH

Reg. Dist. No. 4316

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2320 Gross Avenue</u>				d. STREET ADDRESS <u>2320 Gross Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mrs. Alice</u> Middle <u>Young</u> Last <u>Young</u>				4. DATE OF DEATH Month <u>April</u> Day <u>14th</u> Year <u>1960</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 8, 1866</u>	
9. AGE (In years last birthday) <u>93</u> yrs.		10. IF UNDER 1 YEAR Months <u>93</u> Days <u>93</u> Hours <u>93</u> Min. <u>93</u>		11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Miller</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>				16. SOCIAL SECURITY NO. <u>?</u>			
17. INFORMANT <u>Mr. Harry A. Young</u>				Address <u>2320 Gross Avenue.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adeno carcinoma of Breast c</u> <u>170X</u> DUE TO <u>metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>?</u> DUE TO <u>?</u> (c) <u>?</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 YR.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 10, 1960</u> , to <u>April 14, 1960</u> , that I last saw the deceased alive on <u>April 10, 1960</u> , and that death occurred at <u>8:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles Allen</u>				ADDRESS (Street, city or town, state) <u>Fort Howard, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Charles Allen</u>				DATE SIGNED <u>April 14/1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/18/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Hanna</u>	
				DATE <u>APR 18 '60</u>			

BP

178X

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

64317

4368

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutions, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u>		c. LENGTH OF STAY IN 1b <u>30yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Jordan Saw Mill Rd.</u>				d. STREET ADDRESS <u>Jordan Saw Mill Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Frank</u> Last <u>Zierk</u>				4. DATE OF DEATH Month <u>Apr</u> Day <u>13</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 10 1876</u>		9. AGE (In years, day, month, year) <u>83</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lithographer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lithographing</u>		11. BIRTHPLACE (State or foreign country) <u>Buffalo, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick Zierk</u>				14. MOTHER'S MAIDEN NAME <u>Lena</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. Wm. Barnes</u>		Address <u>Baltimore 18 Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Vascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Malnutrition</u> DUE TO (c) <u>Malnutrition</u></p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>—</u> o. m. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>A. M. France</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/16/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Hartenstein, New Freedom Pa.</u>				24a. REC'D BY REGISTRAR <u>APR 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1326

4672

NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		RACE [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
PLACE OF DEATH [Faint text]		CITY [Faint text]	
COUNTY [Faint text]		STATE [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]	
MANNER OF DEATH [Faint text]		MEDICAL HISTORY [Faint text]	
PREVIOUS ILLNESS [Faint text]		SURGICAL HISTORY [Faint text]	
DRUGS TAKEN [Faint text]		ALCOHOLIC BEVERAGES [Faint text]	
TOBACCO [Faint text]		OTHER HABITS [Faint text]	
SIGNATURE OF EXAMINER [Faint text]		SIGNATURE OF DECEASED [Faint text]	
DATE OF EXAMINATION [Faint text]		TIME OF EXAMINATION [Faint text]	
PLACE OF EXAMINATION [Faint text]		CITY [Faint text]	
COUNTY [Faint text]		STATE [Faint text]	